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ABSTRACT

Home services has developed as an area of intense interest with recent emphasis on independent living for the elderly. The focus of this report is on one type of in-home service--homemaker-home health aide service. Analyzed are the agencies that provide these services, as well as the services they provide, the clients they serve, their organizational structure and staffing patterns. Their historical development and the sources of payment for their services are also discussed. The homemaker-home health aides are analyzed, including their characteristics, historical and current employment levels, and projected employment requirements and annual openings. Supply issues are also explored. Finally, the outlook for aides is analyzed, with suggestions for actions to assure a sufficient supply and an examination of related employment implications. (KA)

AoA

OCCASIONAL PAPERS IN

GERONTOLOGY

No. 2

Human Resources Issues in the Field of Aging

Homemaker-Home Health Aide Services

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Office of Human Development · Administration on Aging
National Clearinghouse on Aging

CONTENTS

HIGHLIGHTS

The demand for home health services, and hence the employment requirements for homemaker-home health aides, are related to health and welfare legislation, the utilization of home services for which public funds are available under the law, and the philosophy that determines appropriate care.

- Under current legislation, the requirements for homemaker-home health aides are expected to grow from an estimated 60,000 in 1975 to 198,000 in 1990. If legislation were broadened to provide long-term home care for all elderly for whom this is the least expensive form of care, the requirement would reach 253,000 in 1990.
- Under current legislation, openings for homemaker-home health aides are expected to number 33,200 annually between 1975 and 1980, 40,200 between 1980 and 1985, and 44,600 annually between 1985 and 1990. Under a broader legislation, annual openings would number 34,500 between 1975 and 1980, 51,900 between 1980 and 1985, and 54,100 between 1985 and 1990.
- The projected annual openings resulting from persons who transfer out of the occupation are far greater than those resulting from growth, even in this very rapidly growing occupation. Reasons for transfers out include dislike of the work, need for guaranteed hours, work pressures, inability to cope with depressed or difficult clients, transportation problems, and low wages or benefits.
- Among factors that attract workers to the occupation are personal satisfaction, relative job status, availability of part-time work, familiarity of job tasks, and flexibility of the work schedule. The overwhelming personal requirement for the occupation is the desire to help people with basic human needs.
- The supply of applicants to fill positions for aides is sufficiently large that agencies generally do not advertise job openings. The supply should be adequate through the 1970's. However, by the 1980's, agencies may have to actively recruit new aides, provide training and career ladders, offer more competitive wages and benefits, and guarantee a minimum number of hours of work.
- While training of aides is a costly element in the provision of service, it is necessary to assure quality care. Arrangements between agencies and local community colleges or technical schools to provide training and follow-up seminars would ease the financial burden on agencies that are quality conscious, and upgrade the service in those agencies that currently provide no training.

INTRODUCTION

The Comprehensive Older Americans Services Amendments of 1973 direct the Commissioner on Aging to (1) develop information on both current and future needs for workers in the field of aging; (2) provide a broad range of quality training and retraining opportunities, responsive to changing needs of programs in the field of aging; (3) attract a greater number of qualified persons into the field of aging; and (4) help make training programs more responsive to the needs of workers in the field of aging.

Deficiencies in the information currently available on human resources in the field of aging limit the ability of the Commissioner on Aging to carry out these activities. Because of the Bureau of Labor Statistic's (BLS) long experience in analyzing manpower needs, the AoA asked the BLS to help develop the information on employment outlook. This is the second report prepared by the BLS on the need for workers in the field of aging. A study of the nursing home industry was the first publication in AoA's series, *Occasional Papers in Gerontology*.[1]

Home services has developed as an area of intense interest with the recent emphasis on independent living for the elderly. Many types of home services deserve special study, from skilled nursing and therapy provided by visiting professionals to home repair services and meals-on-wheels programs, naming just a few. This report singles out just one type of in-home service—homemaker-home health aide service. The fundamental reason for this choice was the availability of basic employment data from a survey of agencies that provide these services, conducted by the National Council of Homemaker-Home Health Aide Services, Inc. under contract with HEW. Such a data base is a prerequisite for employment analysis or projections. Similar data were not available for other home services at the time of this writing.

Basic research on homemaker-home health aide services already had been done. Several years ago, the Health Services Administration contracted with Brahna Trager, a distinguished author and leader in the home health field, to write *Homemaker-Home Health Aide Services in the United States*.[2] The Trager study fully describes the nature of the services delivered, their historical development, and the process of establishing the service and recruiting and training aides. The BLS study focuses on issues directly affecting employment requirements and supply. It touches on topics already covered in the Trager study only to the extent needed to provide a background for understanding the employment issues.

This report is divided into two parts. Part I analyzes the agencies that provide homemaker-home health aide services, describing the services they provide, the clients they serve, their organizational structure and staffing pattern. Part I also briefly outlines their historical development and discusses the sources of payment for their services. Part II focuses on the homemaker-home health aides—their characteristics, historical and current employment levels, and projected requirements and annual openings. Supply issues also are explored—sources of new entrants and occupational transfers, reasons why persons become homemaker-home health aides, and why some leave the occupation, how they are recruited and trained. Part II also analyzes the outlook for aides, suggesting actions to assure a sufficient supply, and ending with related employment implications.

Most of the data used in this study were collected in a 1973 survey of agencies that provide homemaker-home health aide services. The survey was conducted by the National Association for Homemaker-Home Health Aide Services under contract with the Department of Health, Education, and Welfare (HEW). The association furnished BLS with unpublished survey data, and also provided historical data on employment and on the number of agencies. Other information was collected through in-depth interviews with service providers and experts in the field of homemaker-home health aide services.

Since homemaker-home health aide service is not a separate industry classification in the Decennial Census or the Current Population Survey, an industry employment projection by detailed occupation, similar to that provided for the nursing home industry, cannot be made. The projections that can be made are limited to the one occupation for which data were collected in the 1973 survey—homemaker-home health aides. Therefore, this study only projects employment requirements for

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[1] *AoA Occasional Papers in Gerontology, No. 1, Manpower Needs In the Field of Aging: The Nursing Home Industry, (Office of Human Development, Administration on Aging, 1975)*, DHEW Publication No. (OHD) 76-20082.

[2] Brahna Trager, *Homemaker-Home Health Aide Services in the United States*, (Public Health Services Administration, 1973), DHEW Publication No. (HSM) 73-6407.

homemaker-home health aides; employment data on other staff positions must be collected before requirements projections can be made for administrators, supervisors, intake personnel, and others.

Projecting requirements for homemaker-home health aides is difficult because employment has grown very quickly in recent years, resulting in a curvilinear trend. Time series or association analysis, therefore, cannot be used for long-term projections. Another method based on factors that affect the level of services must be used. Three factors are particularly important in influencing demand for homemaker-home health services: legislation, utilization, and philosophy of care. Since public funds are a major source of payment for homemaker-home health aide services, the projection of the number of jobs for aides will depend greatly on legislative provisions governing reimbursement. The extent to which available public and private funds are in fact utilized for the services is also important. The philosophy of appropriate care—whether public funds should be used to assure the least costly care or the care that best meets the individual's needs—is the third factor affecting employment requirements for aides.

This study uses the following approach to project requirements for homemaker-home health aides. Four projections were developed for every target year, each of the four being based on a different set of assumptions concerning legislation, utilization, and philosophy of care. The maximum employment possible under each assumption set is combined with the projection of employment from the historical trend, resulting in four projection series. Each projection series is discussed in terms of current trends; one is selected as the judgment projection (based on the assumption set most likely to occur, given the historical and current situation); and one is selected as an alternative projection (based on the assumption set that could very possibly occur, given current trends, but would require a change in the current situation). Many variables exist under each assumption set that depend on human factors, especially the degree to which persons will use the available service within the constraints of funding sources. All of the projection series, therefore, should be viewed as gross figures, indicating a general level of requirements, rather than a specific number.

This report was prepared by the Bureau of Labor Statistics, Office of Employment Structure and Trends, with funds provided by the U.S. Department of Health, Education, and Welfare's Administration on Aging, Office of Research, Demonstration, and Manpower Resources, Dr. Martin Sicker, Director. It was prepared by Lois Plunkert Terlizzi under the direction of Anne Kahl.

Part I.

Agencies that Provide Homemaker-Home Health Aide Service

Many different health and welfare agencies provide homemaker-home health aide service. This variety results from the dual historical development of the service which has roots in both the health and welfare sectors of the economy. This section begins with an explanation of just what homemaker-home health aide service is. It then briefly discusses the historical background of the agencies that provide the service and examines their characteristics. Next, the various sources of payment for homemaker-home health aide services are described. Part I concludes with a discussion of the fragmentation of public funding sources.

A. Scope of Homemaker-Home Health Aide Services

Homemaker-home health aide services comprise the personal and homemaking services needed to enable persons who cannot perform basic tasks for themselves to remain in their own homes. The National Council of Homemaker-Home Health Aide Services, Inc.[1] defines homemaker-home health aid service as "an in-home service in which a mature, trained, supervised person works in the home and functions as a member of a team of professional and allied workers providing health and/or social services . . . to help preserve, improve or create wholesome family living and prevent family breakdown. It is needed:

- when the mother of the family is ill or incapacitated.
- when aging or handicapped individuals need personal care and assistance with domestic routines to maintain themselves in their own homes.
- when a hospital stay can be averted or shortened by provision of adequate in-home services.
- when children or aged persons are neglected or abused.

Homemaker-home health aide service consists of 2 basic elements; 1) The supervisor's evaluation of the specific services needed by the client; and 2) performance of these assigned services by a homemaker-home health aide. The basic duties performed by the homemaker-home health aide are practical homemaking and personal care services. However, aides also instruct, provide emotional support, and help assess a client's progress. Homemaker-home health aides are employees of an agency that assigns and supervises work and usually provides training.

Homemaker-home health aides provide many homemaking services. Cleaning the client's room, the kitchen, and the bathroom are basic duties. Homemaker-home health aides plan meals (including special diets), shop for food, and prepare meals, usually preparing enough food for a second meal. Homemaking duties also include doing the laundry and changing bed linens.

Among the personal services that homemaker-home health aides perform are assisting with bathing or giving a bed bath, shampooing hair, and helping the client move from bed to a chair or another room. Homemaker-home health aides also check pulse and respiration, help with simple prescribed exercises, and assist with medications. Occasionally, homemaker-home health aides change dressings, use special equipment such as an hydraulic lift, or assist with braces or artificial limbs.

In addition to these practical aspects of the work, homemaker-home health aides offer instruction and psychological support. They often teach clients how to adapt their lives to cope with a new disability or to prevent further illness. For example, a homemaker-home health aide may teach a client who has a very low income how to plan nutritious, low-cost meals. Another client may need instruction on the proper diet for a diabetic. Still another client, newly confined to a wheel chair, may need help in learning how to perform daily tasks. At times an aide may help a client establish a daily schedule that accomplishes necessary household duties and provide necessary exercise for rehabilitation. Providing emotional support and understanding when a client is depressed and lonely is another aspect of the work. This often is more important than the practical jobs since, at times, a sick person's inability to gain strength and independence is more the result of a mental attitude than a physical problem. Lastly, the aide regularly reports changes in the client's condition and helps a professional team decide when the services being given to the client should be changed.

A supervisor, a registered nurse or social worker who usually is part of a professional team of health and social workers, assigns specific duties. The supervisor usually consults the client's physician, especially if the client recently has been

[1] National Council for Homemaker-Home Health Aide Services, Inc., 67 Irving Place, New York, New York 10019.

discharged from the hospital. Many public or nonprofit agencies require physician certification of the need for the service. The supervisor visits the client to decide what services are needed and to discuss the aide's schedule of duties with the client. Often the homemaker-home health aide gives the supervisor a daily report, signed by the client, listing the exact services performed and the hours worked. The supervisor occasionally visits the client to determine if the service is satisfactory.

B. Historical Development

An understanding of the current and projected employment of homemaker-home health aides requires some familiarity with the historical development of these services. A brief outline of this development follows.[1]

The majority of multi-service agencies that provide homemaker-home health aide service are evenly distributed between health and welfare agencies. The current situation results from the development of homemaking service in welfare agencies and home health aide service in health agencies.

Welfare agencies. The first agencies to offer homemaker-home health aide services were welfare agencies. In the early 1900's, private charitable family agencies provided homemakers to care for children whose mother was sick. During the Great Depression of the 1930's, a Works Progress Administration housekeeper project gave homemaking service a temporary boost. Poor and unemployed women were hired as housekeepers for other poor persons in need of the service. After the depression, the provision of homemaking service returned to the private sectors, continuing to center on child care and family life. However, changes slowly occurred over the next 30 years as more agencies offered limited service to adults. By 1958, 145 agencies offered homemaker-home health aide service. About one-half served adults (particularly the elderly) as well as families with children; about one-fourth were public agencies (see chart 1).

After 1958, the number of agencies that offer homemaking-home health aide service grew rapidly, with the percent that were public agencies comprising a larger portion with each survey through 1967. In 1963, there were 303 agencies, 39 percent of them public; in 1966-67 there were 759 agencies, 59 percent public.

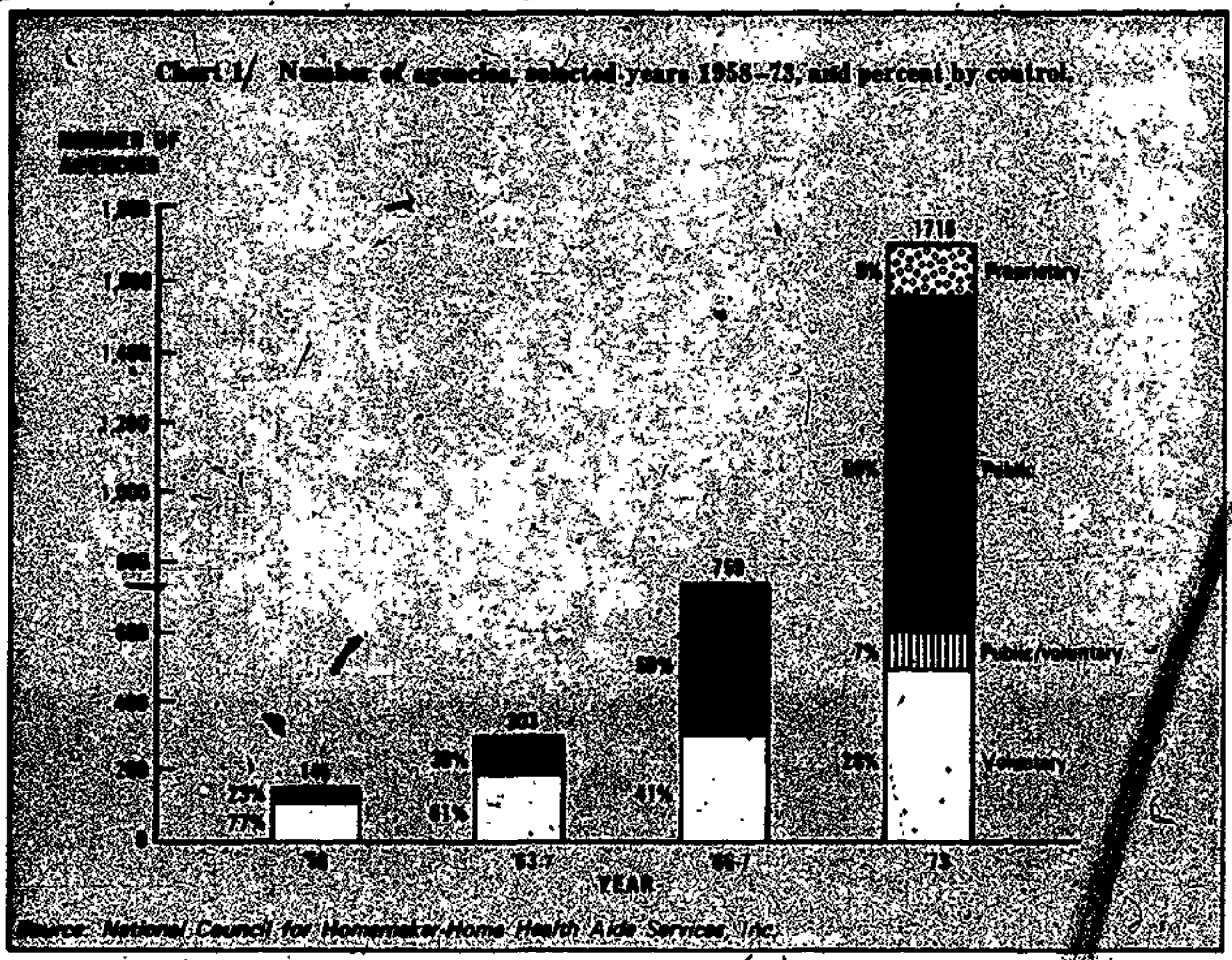
With the passage of Medicare and Medicaid legislation in 1965, the emphasis of service started to shift dramatically away from family and child care toward serving the elderly. Many welfare agencies that had offered homemaker service broadened their service to homemaker-home health aide service, adding more personal care. Two factors contributed to this shift toward personal care: 1) caring for a sick, elderly person required an emphasis on personal care while caring for the children of an ill parent required primarily homemaking duties; and 2) Medicare and Medicaid reimbursed only for the personal care aspects of the work.

By 1973, the number of agencies that offered homemaker-home health aide service had grown to 1,716. The percent that were voluntary continued to decrease—from 77 percent in 1958 to 28 percent in 1973. However, the percent that were public also had decreased slightly since the 1966–67 survey, from 59 percent to 56 percent. This resulted from the emergence of proprietary agencies, growing from none reported in 1966–67 to 9 percent of all agencies in 1973.

The extent to which agencies had shifted the emphasis of services by 1973 is remarkable. While half of the agencies served only families with children in 1958, the portion decreased to 5 percent by 1973, with parent/child care accounting for only 11 percent of homemaker-home health aide service in all agencies. In addition, many agencies—14 percent of the total in 1973—were established to serve only adults.

Health agencies. While welfare agencies were slowly broadening their homemaking service to include personal care of the elderly, health agencies started to add homemaker-home aide service to their in-home services. Health agencies that offer care in the home had long provided skilled nursing services. Some also provided home health aide service, as a supplement to the nursing service. However, with the passage of Medicare and Medicaid, many other health agencies that previously only offered skilled nursing services added home health aides. This followed from the Medicare and Medicaid legislation. In order to provide home services under Medicare, a certified home health agency must provide skilled nursing care plus at least one other service—physical therapy, speech therapy, occupational therapy, medical social work, or home health aide service. Since both homemaking and personal care (health aide)

[1] For more complete treatment of the historical development of homemaker-home health aide services, see Brahna Trager, *Homemaker/Home Health Aide Service in the United States*, (U.S. Public Health Service, Health Services Administration, 1973), Publication No. (HSM) 73-6407, pp. 5-14.



services are needed to maintain a sick person in the home, and since other Social Security Act Titles (formerly Title VI, now Title XX) reimburse for homemaker services, a large number of home nursing agencies introduced homemaker-home health aide service when they applied for certification as a Medicare and Medicaid provider. A certified home health agency also may subcontract the home health aide service, prompting the growth of homemaker-home health aid service agencies. These agencies that provide only this single service comprise 24 percent of all agencies that offered homemaker-home health aide service in 1973.

Combined role. Combining the work done by homemakers in welfare agencies and home health aides in health agencies into a single occupation was a logical step. Certainly, the homemaker provided some personal services as needed, such as helping the sick client into and out of bed. Similarly, the home health aide would perform various homemaking services, such as tidying up the sick client's room. Both personal and homemaking services are required to enable sick persons to remain in their homes. If two different persons had to serve each client—one homemaker and one home health aide—the duplication in time, effort, personnel, and money would be extremely wasteful. To avoid such waste, HEW developed standards in 1965 which established that a single person, the homemaker-home health aide, would provide both homemaking and personal care services. These standards were further clarified and principles for quality of care were enunciated in a 1968 conference sponsored by HEW.

In actual practice, agencies use many different titles—homemaker, home health aide, homemaker-home health aide. The persistence in retaining the titles of homemaker or home health aide results from the fragmentation of the public funds for the services—Medicare and Medicaid reimburse for the personal care tasks of a home health aide, while Title XX reimbuses for the tasks of a homemaker. In addition, the State training requirements for homemakers, if any, usually differ from the Federal and State training re-

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quirements for home health aides. This has encouraged some agencies to retain two distinct types of employees—homemakers and home health aides. Although various titles may indicate differences in the emphasis of service, generally homemakers provide at least minimal personal care, when required, and home health aides provide some necessary homemaking services. Section, D of Part I further explores the relationship between funding and the services provided.

C. Characteristics of Agencies

This section reviews the characteristics of the agencies that provide homemaker-home health aide services—the goals of the services they offer, who they serve, how the agencies are organized and staffed, and what additional services they coordinate with the help of volunteers. All of these agency characteristics affect the supply and demand for homemaker-home health aides. The discussion is based almost entirely on unpublished data from a 1973 survey conducted by the National Council for Homemaker-Home Health Aide Services under contract with HEW. The association surveyed all agencies that provide homemaker-home health aide services. Results of this survey supply the most recent agency data.[1]

The homemaker-home health aide services that agencies offer can be viewed according to their goals. The survey identified four goals of service; substitute for parent care, maintenance of functioning, improved functioning, and higher quality of life. Most agencies offer services to accomplish at least two of the four goals.

- 56 percent provide substitute and/or supplementary parent care for children;
- 83 percent offer supportive services for the aged and or disabled, with the goal of maintenance;
- 84 percent offer personal care and rehabilitation, with the goal of improved functioning;
- 64 percent offer service to raise the quality of life of the individual or the family.

While these data describe the availability of services with various goals, response to another survey question reveals the relative frequency with which services to accomplish each goal was provided. The agencies, taken together, give an average of only 11 percent of their service for substitute and or supplementary parent child care. Supportive services for maintenance comprise 35 percent, services for improved functioning make up 27 percent, and activities to raise the quality of life comprise 13 percent of all services provided. (The remaining 14 percent presumably is given to service with some other goal.)

Some clients are recuperating from an operation and need daily help for one or two weeks. Others have chronic medical problems and need help for one or two half-days a week for an indefinite period of time. At times, homemaker-home health aides work with families when the mother is convalescing from an illness and there are small children who need care. Most clients, however, are elderly persons who either live alone or with a spouse who also has medical problems. Usually the clients have no family or friends who can provide the care that is needed.

Even though most clients are elderly persons, eighty percent of all agencies surveyed provide homemaker-home health aide service both for families with children and for adult families and individuals. Five percent serve only families with children, and 14 percent serve only adult families and individuals.

Agencies that provide homemaker-home health aide service are evenly distributed among urban and rural settings. Thirty-six percent are primarily rural, 37 percent are primarily urban and 27 percent are equally urban and rural. The distribution of agencies by the population size of the area served is only slightly more varied: 25 percent are in an area of under 25,000 population; 32 percent in an area from 25,000 to 100,000; 25 percent from 100,000 to 500,000; and 18 percent over 500,000.

Organizational Structure

Agencies that provide homemaker-home health aide service vary by the number of services offered, the number of units, and the agency control. All of these differences have implications for staffing. A small multiservice agency whose main service is professional nursing, may employ only a few aides, while agencies that only provide homemaker-home health aide services generally employ larger numbers of aides. Data that reveals differences among public, proprietary, and voluntary agencies is valuable to inform public policy decisions.

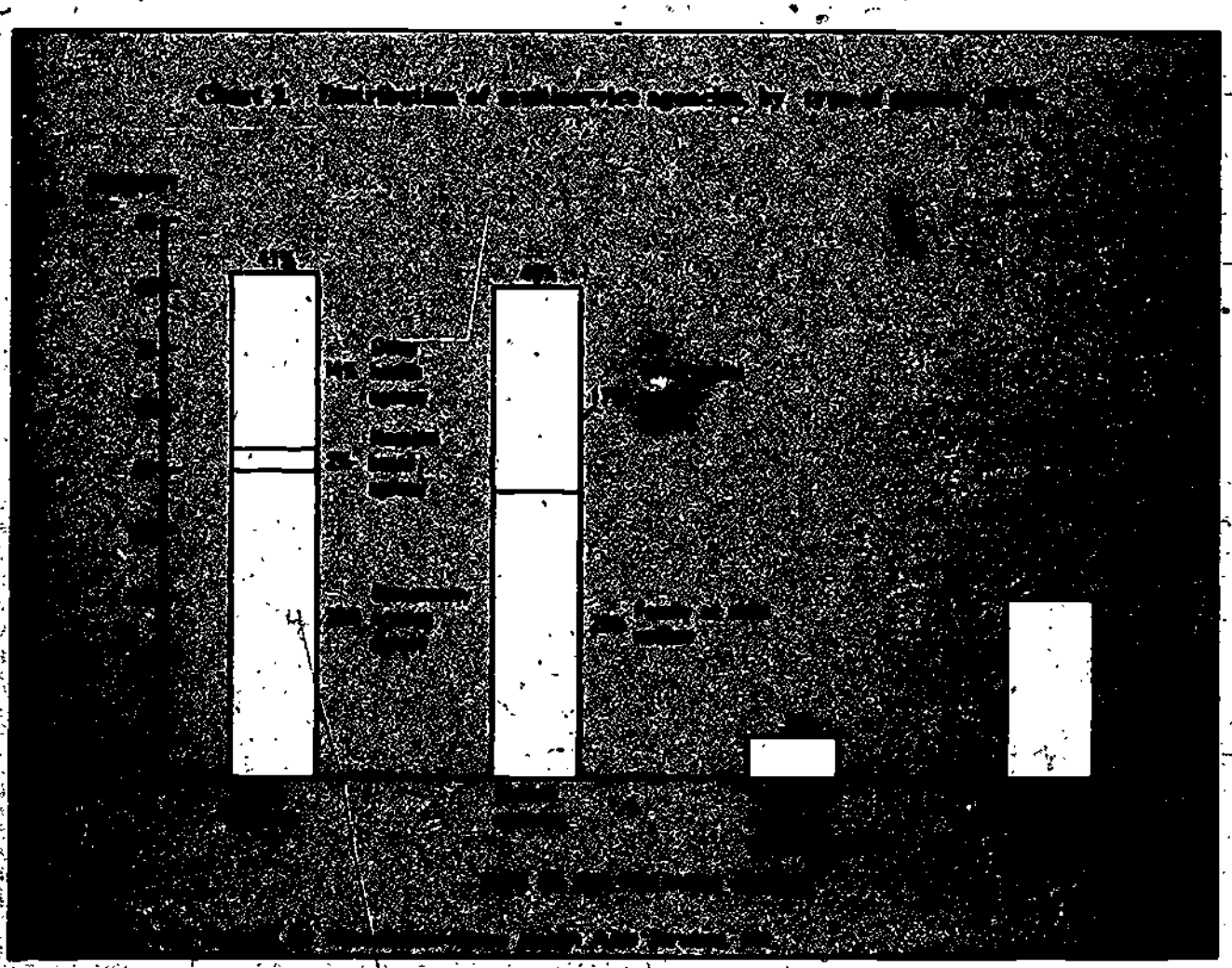
One-fourth of the agencies that provide homemaker-home health aide service offer this service alone. The other three-fourths are multiservice agencies, offering homemaker-home health aide

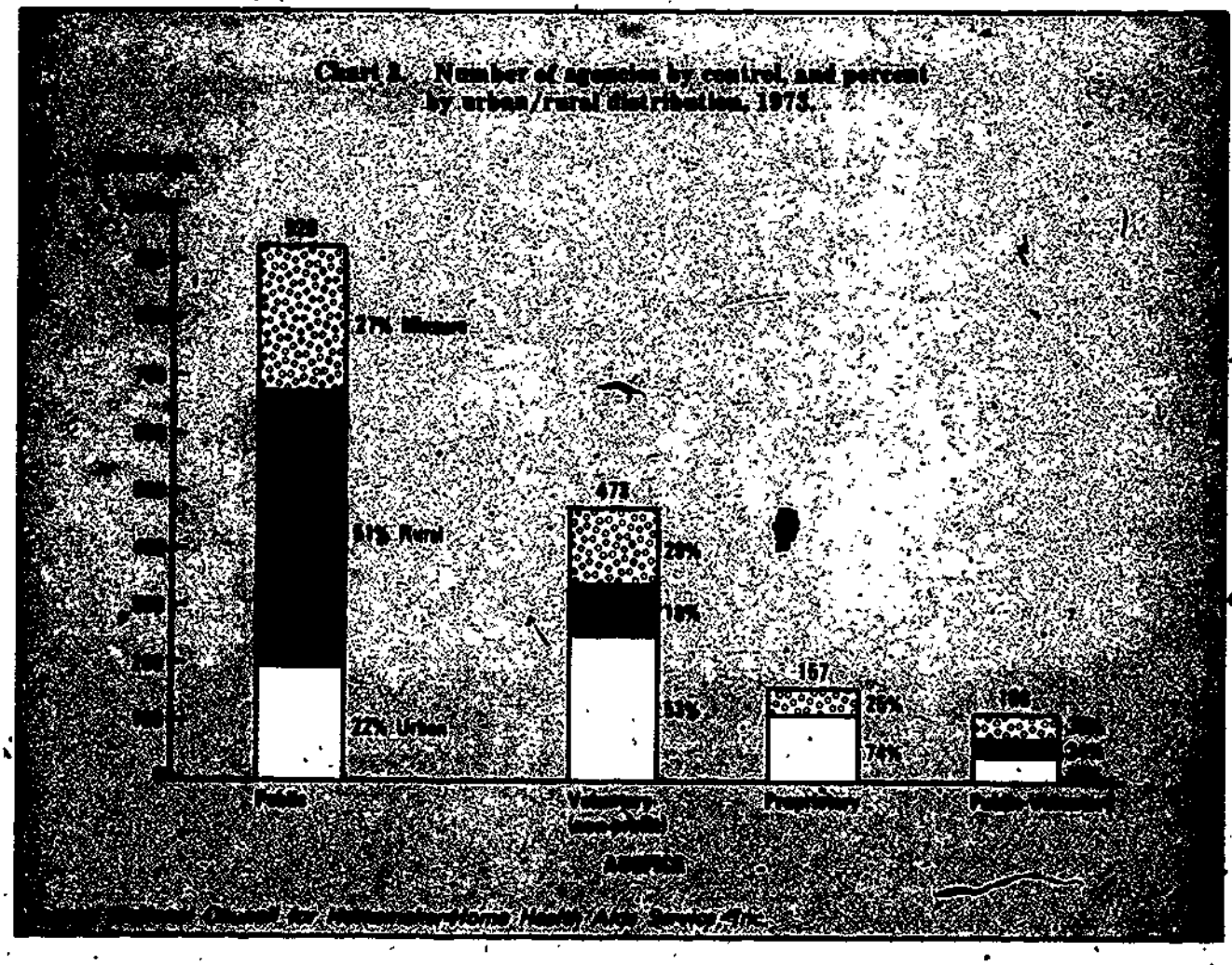
[1] The American Association of Retired Persons-National Retired Teachers Association has funded The National Council for Homemaker-Home Health Aide Services to compile a directory of agencies that provide homemaker-home health aide services. Data was to be collected in 1976 and the directory was to be published in 1977.

service along with at least one other service, such as skilled nursing, therapy, or social service. Chart 2 displays the types of multi-service agencies that offer homemaker-home health aide services. Agencies that provide health services and agencies that provide social welfare services each comprise about 40 percent of the multi-service agencies, three percent are agencies that offer both health and social welfare services, and 15 percent are other agency types. Community nursing agencies such as visiting nurse associations comprise over half of the health oriented agencies that offer homemaker-home health aide service. Other health agencies that provide homemaker-home health aide service include health maintenance organizations, mental health agencies, OEO neighborhood health centers, and prepaid health plans. Family or child welfare agencies comprise over half of the social welfare oriented agencies that offer homemaker-home health aide service. Agencies other than health and welfare agencies that offer homemaker-home health aide service include agencies for the aging, educational institutions, religious organizations, Model Cities, and urban renewal projects.

An analysis of these multi-service agencies distributed by other agency characteristics gives a more detailed picture of homemaker-home health aide services. Agencies that only serve families with children comprise only six percent of all agencies that offer homemaker-home health aide service; the great majority of these agencies are family and child welfare agencies. Agencies that only serve adults comprise 14 percent of all agencies; over half of these are community nursing agencies.

The number of units in an agency affects staffing patterns. Multi-unit agencies generally have more administrative positions than single unit agencies, even if the total number of aides employed is greater in the single unit agency. Two-thirds of all agencies have only one unit, 10 percent are agencies with satellite offices in the same metropolitan area, and 24 percent are organizations with a central office and one or more

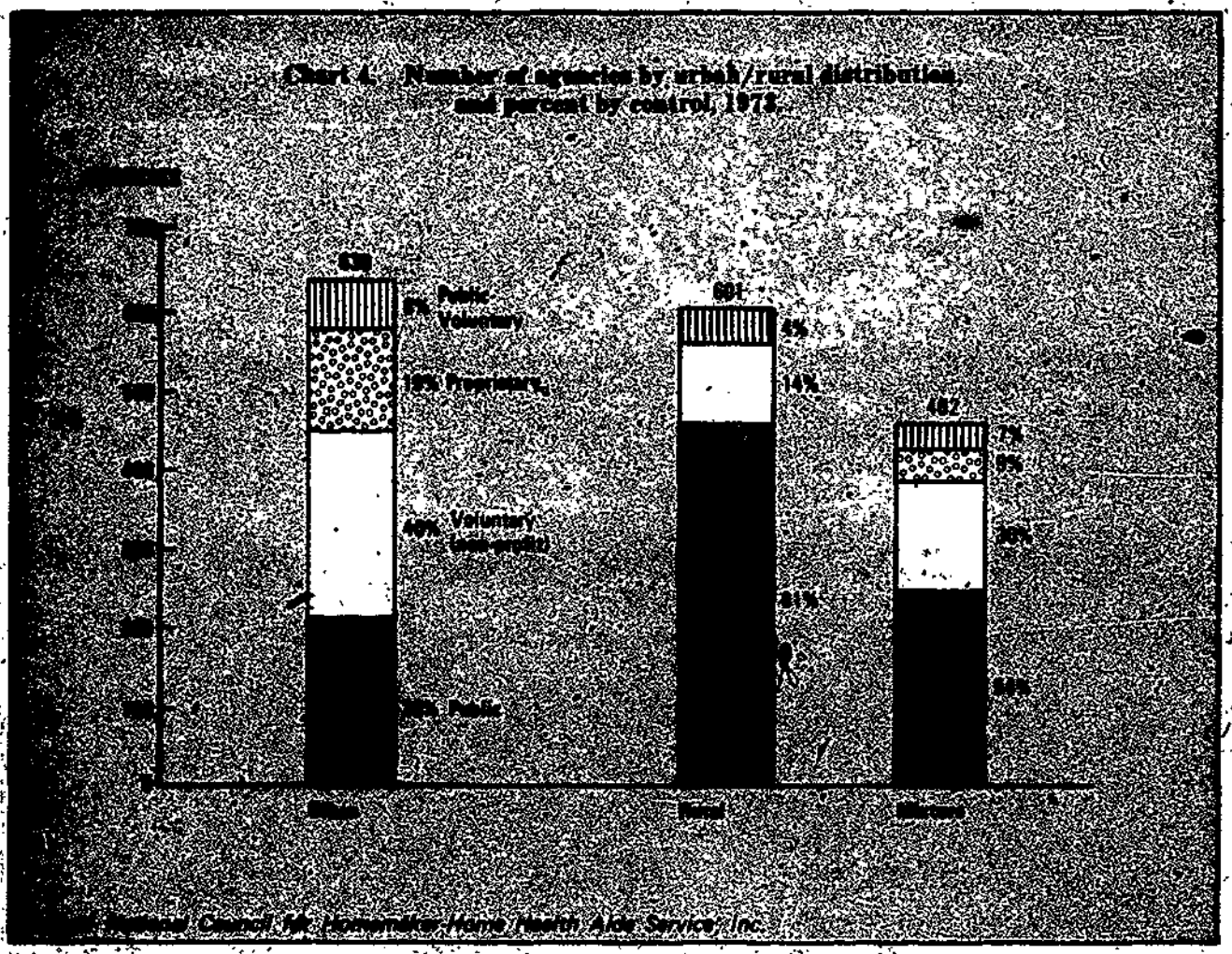




agencies located in a different metropolitan area.

Control. The survey reveals some differences in emphasis of service and clients according to the agency's control. Over half—56 percent—are official public agencies (administered by a government unit and supported by tax funds); 28 percent are voluntary (administered by a non-profit organization and supported by earnings and/or contributions); nine percent are proprietary (administered by an individual, partnership, or profit-making corporation); and seven percent are combined public-voluntary (jointly administered by a voluntary group and a government agency, and supported by both tax funds and contributions). Almost three-fourths of all agencies that serve families with children are public agencies—none are proprietary. When questioned whether they provide supportive services for the aged and/or disabled with a goal of maintenance, only six percent of the proprietary agencies responded no, while 20 percent of the public agencies answered in the negative. Proprietary agencies also answered no less often when asked if they offer personal care and rehabilitation with the goal of improved functioning—five percent negative response compared with 18 percent for public and public-voluntary. However, proprietary agencies offer services to raise the quality of life less often than public agencies, replying no to this question 57 percent of the time compared with 28 percent by public agencies.

Taken together, these data reveal that proprietary agencies more often offer a broader range of basic services than public or voluntary agencies. Conversely, public or voluntary agencies are more likely than proprietary agencies to specialize by serving a particular age group or offering a particular type of service. However, public agencies are much more likely than proprietary agencies to offer services beyond basic maintenance and rehabilitation. An explanation for the greater emphasis on raising the quality of life by public agencies may include: 1) a desire of the public agency to speed along the process of regaining independence to the point that the service is no



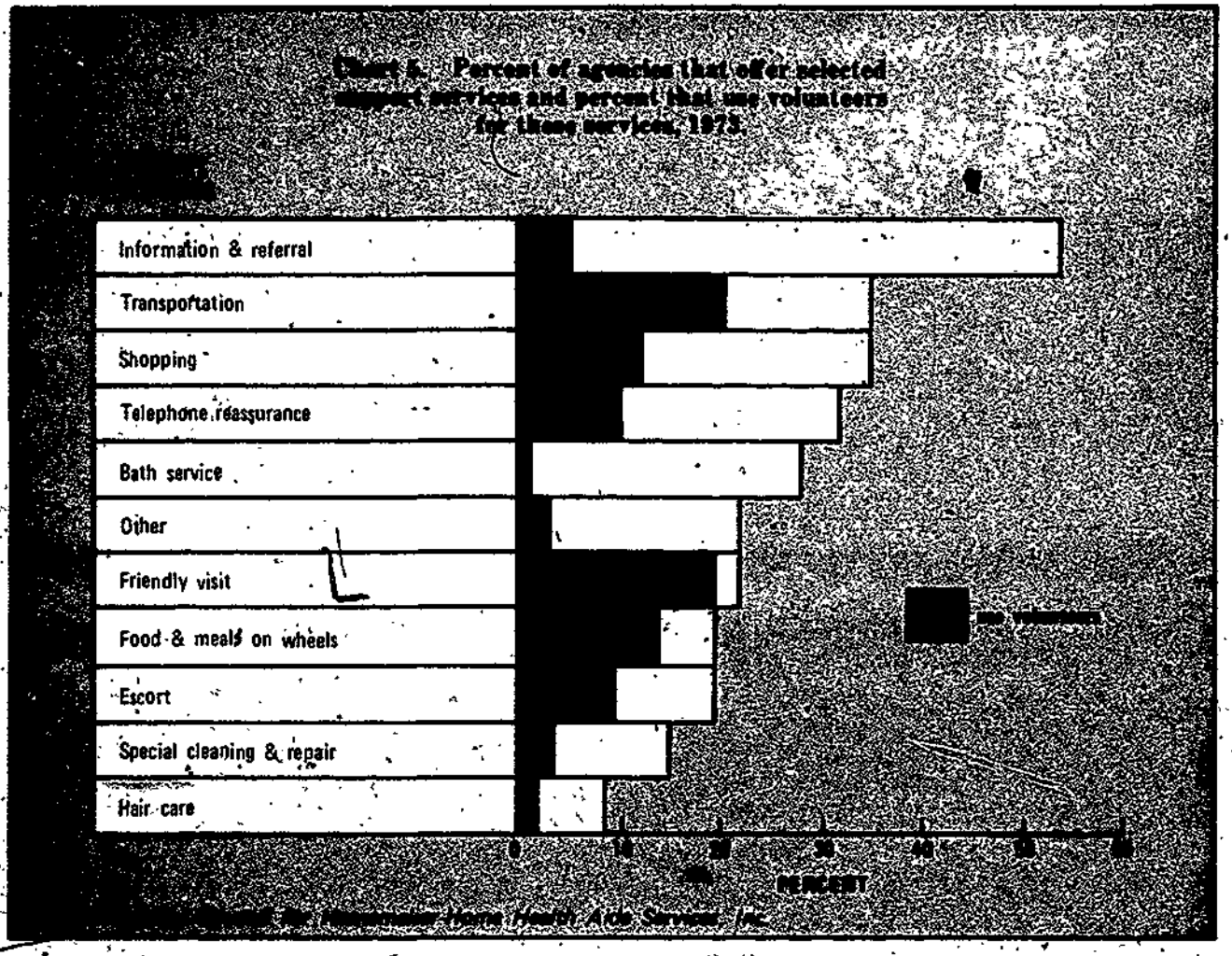
longer needed; 2) the fact that public monies are paying for the service, not the client who usually only can pay for basic maintenance and rehabilitation; and, most importantly, 3) that the quality of life usually is higher for those clients who can afford to purchase the service than for those who receive the service through a public health or welfare agency.

A further insight into the structure of agencies that offer homemaker-home health aide services results from a cross comparison of the agency control with the urban-rural character of the area served (see charts 3 and 4.) Over half of all agencies under public control serve rural areas, and 81 percent of all agencies that serve rural areas are public. Over half of all voluntary agencies serve urban areas, and 40 percent of all urban agencies are voluntary. Proprietary agencies are heavily concentrated in urban areas—74 percent, comprising 19 percent of all urban agencies. This pattern follows an expected course, as areas with a population of sufficient size to assure a large clientele attract agencies that must earn a profit, while less populous areas that could not sustain a profitable business must rely on agencies supported by tax dollars.

Staffing Patterns

A wide spectrum of staffing patterns reflects this great variety in organizational structure. The number of aides employed is a major determinant of the number of supervisors and the number of layers of management required. Whether the agency is multiservice or offers only homemaker-home health aide service is another important factor. The degree to which the agency is committed to quality of care, as evidenced by close supervision of the aides, also influences staffing patterns. Job titles are not uniform; the following examples use the more common titles for staff positions.

A small public health agency may employ five homemaker-home health aides, several nurses, and a physical therapist. The staff may include one administrator; one director of service, who receives requests for service and assigns professionals and aides to cases as required; and one field



supervisor, who oversees the work of the nurses, therapists, and aides. A small agency that offers only homemaker-home health aide service may employ 10 aides supervised by one professional who is a registered nurse or a social worker. The administrator in an agency of this size may perform all of the remaining jobs, such as answering requests for the service and determining which cases to accept.

At the opposite extreme, a large agency that offers only homemaker-home health aide service may employ 150 aides; 10 field supervisors (one for each 15 aides), who are registered nurses or social workers; 2 directors of service, each supervising 5 field supervisors; a director of training; an assistant administrator; an administrator; and separate departments for billing and payroll. A large multi-service agency could have a similar structure, with the field supervisors overseeing a team of nurses, therapists, social workers, and aides.

The average number of aides employed per agency in 1973 was 26—eight full time, 10 part time, and eight on call.[a] If only homemaker-home health aide service is offered, this agency may employ two field supervisors, a director of service, and an executive director.

The executive director and the assistant director positions usually require a masters degree in nursing or social work and administrative experience. However, some agencies, mainly the proprietaries, prefer persons who have a background in business administration.

Support Services

Most of the agencies that offered homemaker-home health aide service in 1973 also offered at least one nonprofessional supportive service—a personal or homemaking service offered separately from regular homemaker-home health aide service (see chart 5). Just over half of all agencies offered

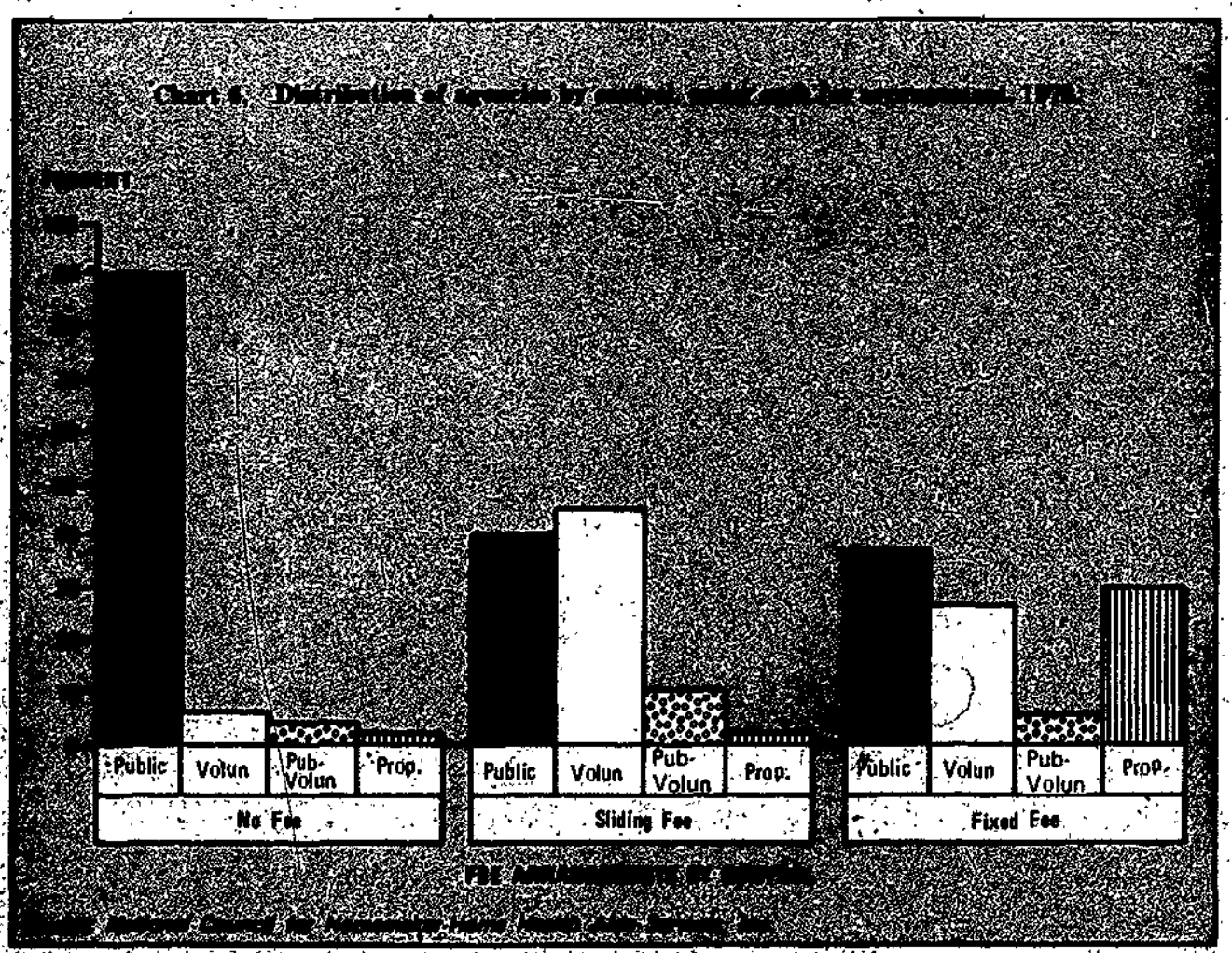
[a] This average number, however, is not a typical agency size. Most agencies are smaller, but a few are much larger, causing the arithmetic mean to be a misleading measure of central tendency. Part II discusses this further.

information and referral service, directing persons who contact the agency for help to other sources for meeting their needs. Thirty-five percent of all agencies offered transportation service, driving clients to medical appointments or stores. Thirty-five percent also provided shopping service, buying groceries or personal items and delivering them to the client. Thirty-one percent provided telephone reassurance, regularly calling persons who live alone to check that they are well. Twenty-eight percent offered bath service as a special service apart from regular homemaker-home health aides' duties. Twenty-one percent coordinated a friendly visitor program, providing companionship and conversation periodically for homebound persons who live alone. Nineteen percent provided food service, either in a congregate setting or delivered to the home (meals on wheels). Eighteen percent offered an escort service, accompanying the client on trips to physicians' offices or stores. Only 14 percent of the agencies offered special cleaning or repair service. This is surprisingly low since this service would be a natural extension of homemaking duties and since performing routine maintenance and occasional heavy cleaning are essential for maintaining persons in their homes. Only eight percent of the agencies offered hair care as an extra service. In most agencies, routine hair care, as needed, is included in normal homemaker-home health aide duties.

Chart 5 also shows the extent to which the agencies use volunteers for each support service. Almost all of the agencies that provided friendly visitor service used volunteers. Sixty-three percent of the agencies that offered some food service and 57 percent that offered transportation service used volunteers. With the exception of escort service, in which 43 percent of the agencies used volunteers, less than one-third of the agencies that offered the remaining support services used volunteers in the provision of these services.

D. Reimbursement Problems

Payment for homemaker-home health aide service comes from a variety of sources. Some agen-



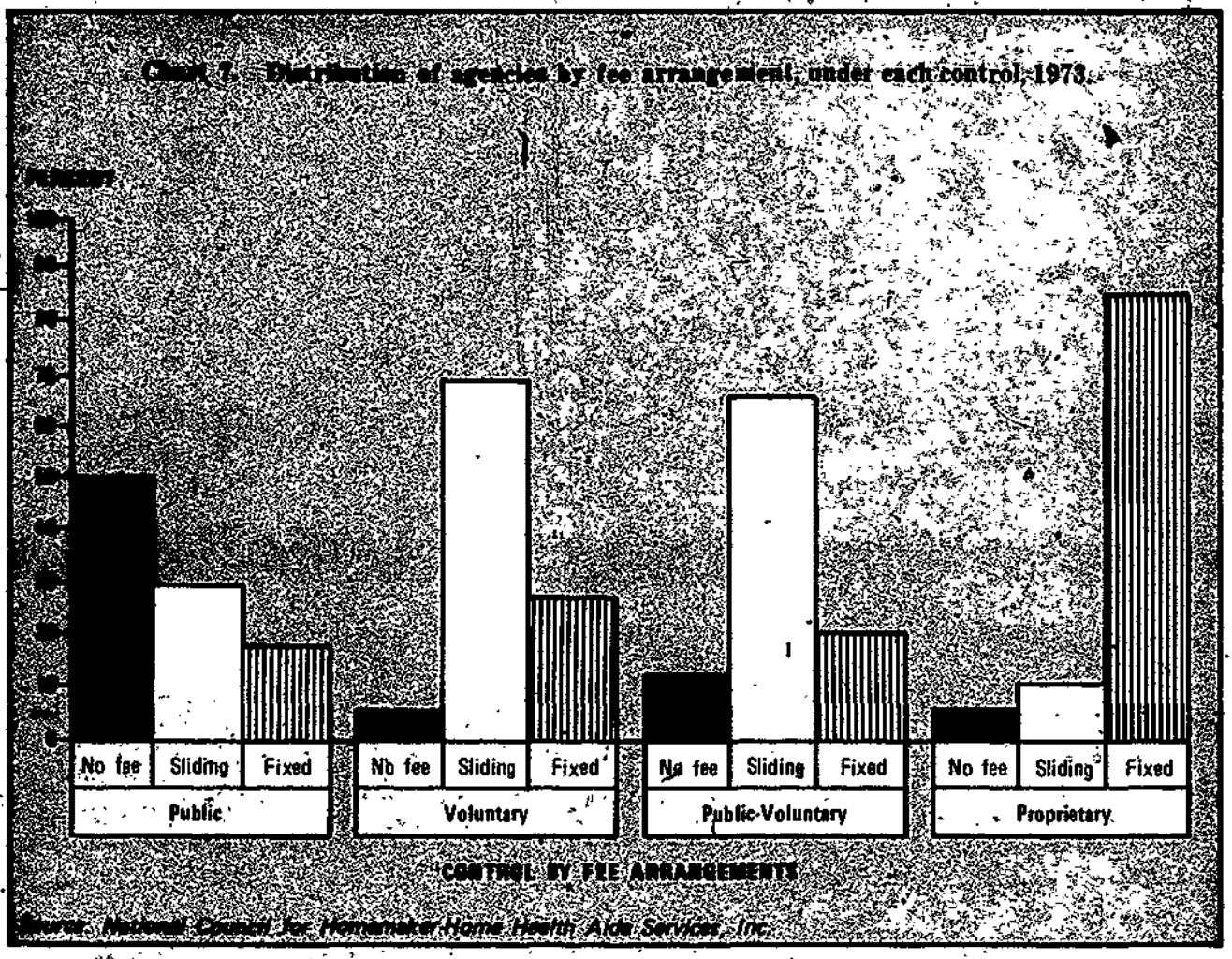


Chart 7. Distribution of agencies by fee arrangement, under each control, 1973.

Source: National Council for Homemaker-Home Health Aide Services, Inc.

cies charge fees while others do not, receiving payment instead from charitable contributions or public funding sources, or both. This section explores the maze of payment sources, examines some of the specific problems with Medicare and Medicaid, and briefly reviews some of the current discussion concerning possible changes in public funding for home care.

Sources of Payment

Most agencies draw their income from a combination of three sources—the client, voluntary contributions and public funds.

The client. Most agencies retrieve at least part of the cost of homemaker-home health aide service by charging the client a fee. Twenty-seven percent of all agencies have one fixed fee for all clients (that does not necessarily cover the cost of service); 41 percent have a sliding fee scale (that may range from full recovery of cost to no fee, depending on ability of the client to pay); and 32 percent charge no fee. Chart 6 pictures the breakout of fee arrangements by agency control, and chart 7 depicts the distribution of agency control by fee arrangements.

Ninety-two percent of all agencies that charge no fee are public agencies—the service is completely financed through public funds. However, only 52 percent of the public agencies charge no fee; 30 percent have a sliding scale; and 18 percent charge a fixed rate. Although public agencies mainly serve low income persons, the charge of some fee by almost half of these agencies demonstrates an attempt to recover part of the cost of providing the service. In many cases, the fee also reflects the philosophy that a token payment is psychologically preferable to a free service.

Voluntary agencies charge the sliding scale fee most often. Forty-seven percent of all sliding scale agencies are voluntary and 69 percent of all voluntary agencies have a sliding scale. Since a basic source of funding for voluntary organizations is contributions (for example, the United Way), and since this is an extremely limited funding source, voluntary agencies recover as much of

the cost as possible through fees.

Eighty-five percent of all proprietary agencies charge a fixed fee. At the time of the survey, Medicare and Medicaid reimbursed proprietary agencies for home health care only in those States that license these agencies (11 States in early 1976). Therefore most proprietary agencies had to recover all costs through the fee paid by the client. However, in August 1975, HEW issued proposed regulations permitting public and voluntary agencies to arrange with proprietary agencies for home health services under Medicaid. Under these proposed regulations, still not final at this writing, the contracting public and voluntary agencies would be required to assume control and supervision of their services as if they were provided by their own employees.[1]

When a fee is charged, the client almost always pays it "out of pocket." However, in some cases, private health insurance policies reimburse for part or all of the service. Very tight restrictions govern these benefits, which insurers generally pay only if the person otherwise would be hospitalized, resulting in a cost saving to the insurance company.

Religious groups such as the Council of Churches, Jewish Homes, and Catholic Committee on Aging are additional sources of contributions for homemaker-home health aide services.

Public funds. A variety of public programs provide funds to purchase homemaker-home health aide service. The basic source of public funding for the homemaker portion of the service is Title XX (replacing Title VI) of the Social Security Act, which authorized payment for social services (see Table 1.) However, each State determines the social services to be funded under Title XX, defining the services and any quality controls for delivery of the service. Therefore, even if a State funds homemaker service, there may be little or no professional assessment or supervision of the worker. There is a "ceiling" or limit on the funds available to each State under Title XX, and the State is required to match the funds used.

By contrast, Title XVIII of the Social Security Act (Medicare) reimburses for personal care performed by a homemaker-home health aide in specific circumstances. It does not have a limit on funding (is open-ended) and does not require State matching funds. Title XIX (Medicaid), that reimburses for personal services, has fewer restrictions than Medicare. Like Medicare, it is open-ended, and, like Title XX, it must be matched by State funds. Many States currently are spending up to the legal limit on Title XX services. The amount devoted to homemaker-home health aide service varies; in some States, as much as 24 percent of Title XX funds are being used for homemaker services. By contrast, Medicare and Medicaid funds—which are not subject to a dollar "ceiling"—are used very little for home health services (less than 1 percent of all Medicare and

Table 1. Comparison of Titles XVIII, XIX, and XX of the Social Security Act.

Social Security Act	*Service*	*Target Group*	*Duration*	*Limits on funds*	*Utilization of home care provisions*	*Quality control in home service*
Title XVIII medicare	Health (personal care)	Elderly	Short-term, acute care	Open-ended—no state matching	Underutilized	Federal standards
Title XIX medicaid	Health (personal care)	Poor	Short and long-term (acute and chronic)	Open-ended—state matching	Underutilized	Combined Federal and State Standards
Title XX (replaces Title VI)	Social (home making)	Poor and low-middle income	Short and long-term (acute and chronic)	Closed—state matching	High utilization	States set standards

Contributions. While most voluntary agencies recover a part of their costs through fees, these agencies rely heavily on contributions to meet their annual budget. The United Way is the basic source for contributions. Disease related charities are also important sources—Cancer Society, Heart Fund, United Cerebral Palsy Association, Easter Seal Society, Lung Association, and others.

[1] The effect this change in regulation would have on the number of proprietary agencies or on their fee arrangements is unknown at this point.

Medicaid expenditures). The Government Accounting Office (GAO) completed a study of the underutilization of home health care benefits under Medicare and Medicaid in July, 1974. The following is a very brief summary of their findings and recommendations.

Medicare home health benefits emphasize skilled nursing care, reimbursing the cost of only the personal care services of a home health aide, and only if the client also needs professional nursing or therapy care. A physician must declare a patient homebound and prescribe the home health aide service, which is limited to 100 visits per calendar year and per illness. Part A of Medicare requires hospitalization of the client for at least 3 days immediately prior to prescribing home health care. Part B, medical insurance, does not require hospitalization for home health care eligibility.

From the beginning of Medicare, confusion surrounded the home health care benefits. Inconsistencies in the coverage of services and number of visits for specific illnesses caused a major problem for providing agencies when payment was denied for services that had already been furnished. This retroactive denial of payment was particulary devastating to new agencies. As a result, Medicare expenditures for home health benefits declined between 1970 and 1973. GAO recommended that the Social Security Administration increase its efforts to assure uniform guidelines for home health benefits, and that they encourage health professionals' awareness and support of home health care.

Medicaid provides broader home health coverage that Medicare. Home health services is a required benefit under Medicaid, and home-health aide service is a required component under that benefit. While both Medicare and Medicaid require that services be provided by a certified home health agency, Medicaid does not demand that the client be in need of professional nursing or therapy services to qualify for personal care by a home health aide. Instead, anyone who is eligible for skilled nursing home services under Medicaid also is eligible for Medicaid coverage of home health services. In addition the services for which Medicaid reimburses are broader, including preventive care. However, as with Medicare, the specific covered services are unclear, and, as a result, the States differ widely in their Medicaid coverage, with many States offering little or no home health aide care. The GAO recommends that the Social and Rehabilitation Service clarify the specific home health services that must be included in Medicaid coverage, encourage the use of home health care when it is less expensive than institutionalization, encourage the States to establish payment rates that adequately cover cost of the service, and assist the agencies in their attempt to increase health professionals' awareness of the potential of home health care as an alternative to institutionalization.

While Titles XVIII, XIX, and XX of the Social Security Act are of foremost importance as sources of public funds for homemaker-home health aide services, many other public funding sources exist—special need welfare grants, "after care" mental health programs, Model Cities funds, Revenue Sharing funds, and Older Americans Act Title III funds for start-up grants.

Public funds, the main source of reimbursement for homemaker-home health aide services in public agencies, also are an important payment source for many non-public agencies. Public agencies often purchase homemaker-home health aide services under contract. For example, while some public health or welfare agencies employ their own homemaker-home health aides, many others contract with voluntary agencies to provide the service. In other cases, voluntary home health agencies such as visiting nurse associations may subcontract with another agency to provide homemaker-home health service.

Long-Term Care

Reimbursement problems are grave in the case of elderly persons who require long-term care for chronic health conditions. A variety of settings provide different levels of long-term care. Skilled nursing facilities provide the highest level of care, followed by intermediate care facilities, which provide less intensive nursing care. Personal care homes serve persons who are unable to live alone but who do not require nursing supervision. Homemaker-home health aide services, combined with other in-home services, provide long-term care for persons who do not require 24-hour personal care.

Appropriate level of care. Many of the one million or more elderly people in institutions are not receiving appropriate care. The principal problem is placement in facilities whose services are more elaborate and costly than necessary. Many persons in skilled nursing homes could receive adequate care in an intermediate care facility, personal care home, or even home care. The same situation exists in intermediate care facilities and personal care homes where many persons receive more extensive services than are necessary.

The most underutilized form of long-term care is home care. Great discussion has developed over

home care as an alternative to institutional care. Actually, as is stated above, many elderly people need institutional care. However, institutional care often is used when home care is more appropriate. Two criteria can determine the appropriate level of care: 1) The least costly level that provides the needed care, and 2) the level that most satisfactorily provides the needed care, regardless of cost. Many European countries follow the second criterion, providing extensive and costly service in the home. However, the two criteria often would dictate the same level of service. If a person does not require 24-hour care, home care is generally the level that most satisfactorily provides the needed care (since providing more care than necessary encourages dependence instead of helping the elderly person regain independence). Numerous studies show home care to be less expensive than institutional care when the client can remain in the home with routine home services.[9] However, regardless of the criteria used to determine "appropriate" care, the long-term care given today to large numbers of the elderly is inappropriate, since placing persons in a higher level of care than necessary encourages needless dependence and is generally more expensive.

Financing long-term homemaker-home health aide services. Sources of payment for homemaker-home health aide services vary according to the nature of the client's condition. As was discussed above, Medicare insures the short-term, acute care client—it covers home health aide service only as long as the elderly person also requires skilled nursing care, and it is limited to 100 visits per year and per illness. Many States extend this limitation to Medicaid also, against the intent of the law.[10] Medicare (and in some States Medicaide), then, pays for personal care by a homemaker-home health aide only if the elderly client requires short-term, acute care, and does not pay for homemaker service at all.

If clients need long-term care, or if they need personal and homemaking care but are not so ill as to require skilled nursing care, the sources of payment depend on the ability of the clients to pay for the service. Persons who can afford to pay can purchase the service from a proprietary agency or, in some cases, from a voluntary agency (subject to assessment of need for the service). Persons who qualify for welfare may receive the service under Title XIX or Title XX of the Social Security Act. A small number may qualify under one of the other public sources mentioned above. The great majority of the elderly, however, neither qualify for welfare nor can pay for the service for an extended time; voluntary agencies are their only hope for receiving the service. With limited contributions as the source of payment, the voluntary agencies can serve only the persons most in need, turning away the majority of applicants.

Alternative funding proposals. Persons concerned about care of the elderly suggest various improvements in providing homemaker-home health aide service and making it available to persons who cannot afford to pay for it. Two current suggestions of service providers, legislators, and experts on home health care for change in the Social Security legislation are discussed here.[11]

First, service providers and others in the field propose that both Medicare and Medicaid be extended to include homemaking as well as personal care. As we have already seen, Title XX reimburses for homemaking services and Titles XVIII and XIX for health services. Some provider agencies suggest that the homemaker service covered in Title XX be shifted to Title XIX, since the target group and duration of service are the same under both, and the service is provided by the same person. This shift would release the limited Title XX funds for other social services, would assure quality service under the Medicaid regulations, and would relieve unnecessary paperwork required to receive reimbursement from 2 different sources for routine services provided by 1 person. In addition, it is proposed that Medicare coverage be expanded to include homemaking as well as personal care services. This would enable persons who cannot afford to pay for the homemaking service but who are not eligible for services under Title XX, to receive the necessary services and possibly avoid institutionalization.

The second proposal by persons concerned about long-term care of the elderly would extend Medi-

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[9] Comptroller General of the United States, *Report to the Congress, Home Health Care, Benefits Under Medicare and Medicaid* (General Accounting Office, July 9, 1974).

[10] *Select Committee on Aging, Annual Report for the Year 1975* (U.S. House of Representatives, Select Committee on Aging, 94th Cong., 1st sess., 1976, Committee Print), page 22.

[10] It is not our intention to make a statement on the complex issue of cost comparison. Obviously, however, a limited number of home services could be provided for less cost than institutional care. The question of where the line is drawn remains.

[11] Comptroller General, *Report to the Congress*, pp. 35–7.

The suggestions are recurring themes with service providers and experts in home health care and are included in the "National Home Health Care Act of 1975" that was introduced by Representative Edward Koch to the 94th Congress. *See Congressional Record House*, March 17, 1975, pp. H1863–6.

care eligibility for home and institutional care to long-term cases. For home care this would require 1) the removal of the limit of 100 visits per year and per illness and 2) the removal of the requirements for professional nursing care before home health care is covered. The effect of these changes would be considerable, broadening the thrust of Medicare as it adds long-term care. The number of persons who would use the added home health benefits depends on many factors—awareness of their potential and availability of the service would be major determinants. If home health care were used in each case where it was the "appropriate" level (regardless of the criterion for appropriateness), the increase in utilization would be tremendous. In addition to home care, this proposal would expand Medicare to cover long-term care in skilled nursing facilities, intermediate care facilities, foster care, and day care. Since Medicare has open-ended funding and does not require State matching funds, the cost of the program could increase indefinitely under this proposal.

The alternative to extending Medicare coverage to long-term home health care is continuance of the current situation. Persons who need home health care but who can't afford to pay for it, who are not eligible for welfare, and who are turned away by voluntary organizations have three choices; 1) do without the service until their health further deteriorates and they have to be institutionalized; 2) enter an institution (an inappropriate level of service, turning over what personal assets they have; or 3) pay for homemaker-home health aide service until personal assets are within welfare limits, decrease income below welfare level, then apply for welfare (including Titles XIX and XX homemaker-home health aide benefits). This would be a crushing blow for proud, independent elderly. With all of these alternatives, public funds are the eventual source of payment for the health care of the elderly. Provision of routine homemaker-home health aide services under Medicare, where appropriate to prevent institutionalization, may not only be the method that best preserves human dignity and happiness for the elderly, but in some cases it may prevent more costly care in later years, financed through welfare funds.

Part II.
Homemaker-Home Health Aides

Part I discussed homemaker-home health aide services and the agencies that provide these services. Part II describes homemaker-home health aides themselves, giving a profile of the aides and the number currently employed. Following this is a discussion of supply issues, and then an analysis of the outlook for the occupations through 1990. Several alternative employment projections are presented. Part II ends with some employment implications for supervisors and comments on various related occupations and model projects.

A. A Profile of Homemaker-Home Health Aides

Homemaker-home health aides possess a broad range of personal characteristics, expecially in age, education, and work experience.

Age and sex. Most homemaker-home health aides are middle-aged. However, both the young and the elderly work as aides. The minimum age for a homemaker-home health aide is usually 18; however most agencies prefer people in their twenties at least. Many agencies employ persons who are elderly themselves. Most of these older aides desire part-time employment to supplement their Social Security income.

Almost all homemaker-home health aides are women. Although only a small number of men currently work as aides, additional men are needed, expecially to care for those elderly men who prefer a male aide.

Educational and experience. Experience in homemaking and personal care is the basic requirement for employment as a homemaker-home health aide. Most agencies do not require this experience to be paid employment; successfully managing one's own household and raising one's own family is excellent background for this occupation. Generally, the only educational requirement for employment as a homemaker-home health aide is the ability to read and write; completion of high school usually is not necessary. However, courses in home economics such as meal planning and family living are helpful, especially for younger persons with less personal experience in homemaking.

While most agencies do not require special training or previous employment in a related occupation, there are exceptions. Some agencies require previous training as a nursing aide; some of these agencies also require a year's experience as a nursing aide in a hospital or a nursing home. Generally, agencies that require training or employment experience as a nursing aide provide little initial training or supervision. Some agencies employ post-secondary students whose course work provides a background in the skills required, such as nursing students who want the income from part-time work. College students in appropriate major fields such as home economics or social work occasionally can find summer work as aides, replacing regular employees who are on vacation.

Personal qualities. Homemaker-home health aides must be mature persons who like to help people and don't mind hard work. Although many clients are well-adjusted, self-directing, pleasant persons, other clients are less successful in coping with their illness or state in life. Homemaker-home health aides, therefore, must have a sense of responsibility, compassion, emotional stability, and a cheerful disposition. They must be able to overcome an atmosphere of depression and bring brightness into the day of a sick, elderly person. Homemaker-home health aides also must be tactful and able to get along with all kinds of people.

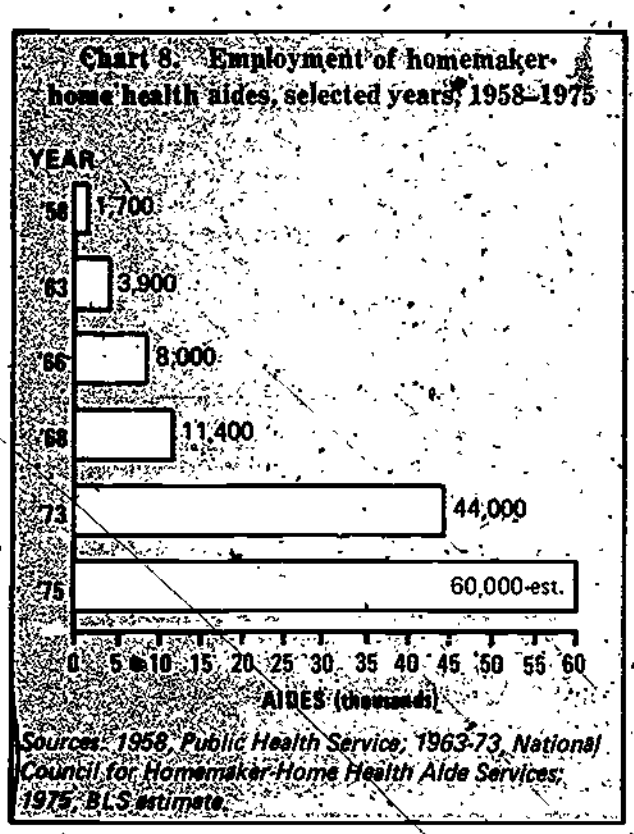
In addition to these personal qualities, homemaker-home health aides must have good health since some of their duties such as lifting, moving, and supporting patients require above average physical strength. A physical examination usually is required of applicants.

B. Historical and Current Employment

Part I traced the slow development of agencies that provide homemaker-home health service from the beginning of the twentieth century through the early 1960's (when publicly funded health insurance for the elderly was first introduced with the Kerr-Mills Medical Assistance to the Aged bill). Agencies experienced faster development during the mid 1960's until Medicare and Medicaid were enacted in 1966. Very rapid expansion followed after this point. Chart 8 traces the corresponding development in the numbers of homemaker-home health aides employed—from 1,700 in 1958, to 44,000 in 1973, and an estimated 60,000 in 1975.

Of the 44,000 homemaker-home health aides employed in 1973, 13,000 were employed on a regular full-time basis; 18,000 were regular part-time employees (less than 35 hours); and 13,000 were on-call employees. Full-time aides worked an average of 38 hours a week and part-time aides worked an average of 17 hours a week.

Number of aides by employment status. Table 2



shows the distribution of providing agencies by the number of homemaker-home health aides employed, broken out by employment status (full-time, part-time, or on-call). While most agencies (70 percent) employ some full-time aides, and about half (47 percent) employ some part-time aides, only about a fourth (26 percent) employ any on-call aides. Table 2 also reveals that the bulk of the agencies employ very few aides, while a few agencies employ an extremely large number of aides. This causes the average (arithmetic mean) number of aides in an agency, discussed in Part I, to be much higher than the representative agency. Only 16 percent of all providing agencies employ more than 10 full-time aides, only 20 percent employ more than 10 part-time aides, and only 10 percent employ more than 10 on-call aides.

Table 2. Distribution of Agencies by Number of Aides in Each Employment Status Category, 1973.

Employment status	*Number of aides employed*				
	Zero	1–10	11–20	21–50	50+
Full-time	30%	54%	7%	6%	3%
Part-time	47%	33%	8%	8%	4%
On-call	74%	16%	3%	3%	4%

Number of agencies by agency control and employment status. An examination of the breakout of employment status by several agency characteristics gives greater insight into the employment picture. Definite contrasts emerge from the breakout by agency control. A public agency is more likely than voluntary or proprietary agencies to employ full-time homemaker-home health aides, and less likely to employ part-time aides or aides on call. Sixty-four percent of all public agencies did not employ part-time aides and 86 percent of all public agencies did not employ on-call aides.

For the most part, both public and voluntary agencies employ small numbers of homemaker-home health aides. However, many voluntary agencies hire large numbers of part-time homemaker home health aides. For example, voluntary agencies comprise only 28 percent of all agencies, yet 47 percent of all agencies that employ from 21 to 50 part-time homemaker home health aides are voluntary agencies.

Most proprietary agencies, on the other hand, employ large numbers of homemaker-home health aides in every employment status category, with the emphasis on part-time and on-call aides. Nine percent of all proprietary agencies employ 50 or more full-time aides, 25 percent employ 50 or more part-time aides, and 29 percent employ 50 or more on-call aides. The numbers of proprietary agencies that employ between 21 and 50 aides in each employment status category also is relatively high, with the emphasis on part-time aides. Twenty-three percent of all proprietary agencies employ from 21 to 50 full-time aides, 34 percent employ from 21 to 50 part-time aides, and 17 percent employ from 21 to 50 on-call aides.

Charts 9, 10, and 11 show these same data, using the numbers of agencies rather than percent, thus emphasizing the actual impact of the percents. Chart 9 pictures the number of agencies that employ full-time aides, broken out by number employed and agency auspice. A glance at chart 9 reveals that most agencies employ at least some full-time homemaker-home health aides, with the great majority of agencies employing 10 or fewer. Chart 10 shows that almost half of all agencies do not employ any part-time aides. The public agencies that do employ part-time homemaker home health aides most often employ 10 or fewer. However, many proprietary and voluntary agencies employ from 21 to 50 homemaker-home health aides. Chart 11 shows that the great majority of agencies do not employ any on-call aides. Of these public and voluntary agencies that do employ on-call aides, most employ 10 or fewer. The great majority of agencies that employ more than 20

Chart 9. Number of agencies that employ full-time aides, by number of full-time aides and by agency control, 1973.

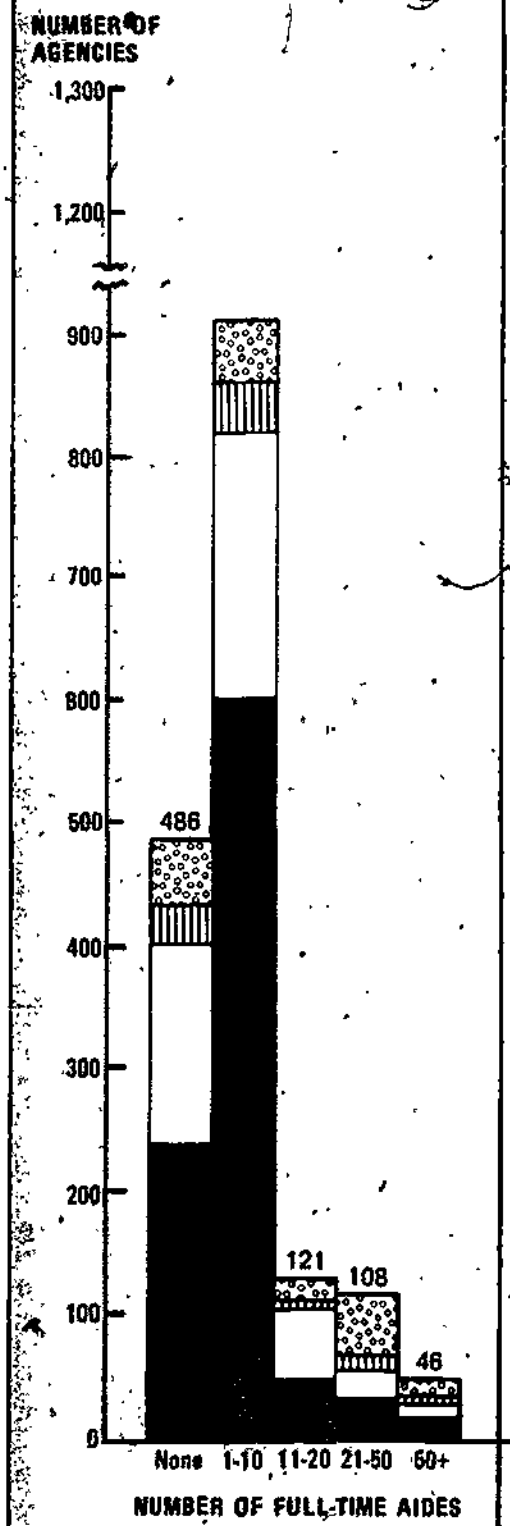


Chart 10. Number of agencies that employ part-time aides, by number of part-time aides and by agency control, 1973.

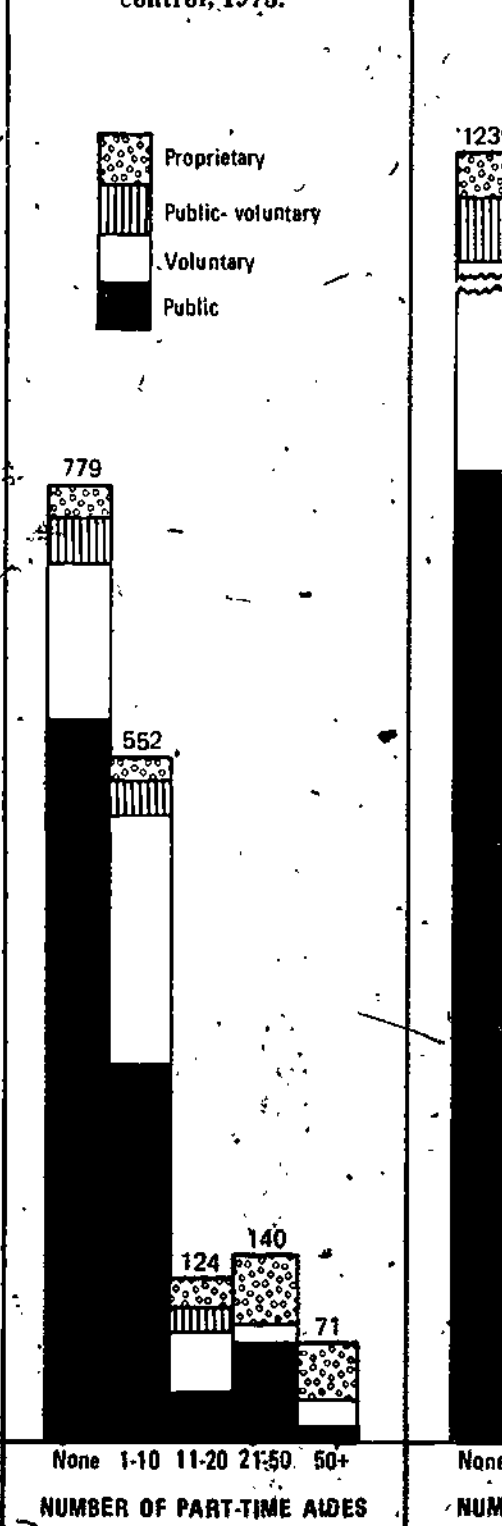


Chart 11. Number of agencies that employ on-call aides, by number of on-call aides and by agency control, 1973.

Source: National Council for Homemaker-Home Health Aide Services, Inc.

on-call homemaker home health aides are proprietary.

Number of aides by other agency characteristics. The breakout of the employment status of aides by other employing agency characteristics yields less spectacular information. Rural agencies are more likely than urban to employ five or fewer aides, and urban are more likely than rural to employ six or more aides in all employment status categories. Agencies that serve only adults are less likely than other agencies to employ full-time homemaker-home health aides, while agencies that serve only families with children are less likely than other agencies to employ part-time homemaker-home health aides. This follows from the differences in the nature of the work in the two types of agencies—substituting for a mother is an all-day job, while helping an elderly person generally requires only a few hours a day, one or two days a week.

Community nursing agencies are less likely than other types of agencies to hire full-time homemaker-home health aides and they are more likely than other agencies to employ from one to five part-time aides. By contrast, family-child and other social welfare agencies are less likely than other types of agencies to hire part-time aides, and they are more likely to employ from one to five full-time aides. These statistics characterize most community nursing agencies as staffed by one to five part-time aides, and most welfare agencies that provide homemaker-home health aide service as staffed by one to five full-time aides.

C. Projections

This section contains projections of (1) employment requirements for homemaker-home health aides in 1980, 1985, and 1990, and (2) annual openings through 1990, that is, the sum of job openings resulting from growth and replacement needs.

Requirements

Two basic approaches can be taken in projecting employment requirements. One method attempts to determine the number of persons required to provide some ideal level of service—a goals criterion for need. For example, Great Britain currently has an official goal of 150 homemaker-home health aides for every 100,000 persons by 1983. The other method seeks to estimate the number of persons required to provide the amount of goods or services demanded—an economic demand criterion for need. This approach is similar to a forecast of employment, provided that the necessary and appropriate supply of labor is available. Of course, the projected requirements figures using the two criteria of need approach each other as the economic demand for the service approaches the ideal level of service.

Since this paper describes the current situation and probable future of homemaker-home health aide services, the economic demand approach is most appropriate for these requirements projections. However, even though this study uses the economic demand criterion, one projection series approaches the projected requirements that would result from a goals criterion for need.

Future requirements for homemaker-home health aides are extremely hard to project. As explained in Part I, the level of employment is determined primarily by the amount of public funds available to purchase the service. Since a change in the Social Security Act or funding under new legislation could occur at any time during the projection period, assumptions must be made as to whether such a change will occur and, if so, what the change would be. The extent to which clients use the available funds to purchase homemaker-home health aide service is another important employment determinant. (The current underutilization of Medicare and Medicaid for home health services already has been noted). Assumptions must be made, then, concerning the degree of utilization in the future. Thirdly, the philosophy of appropriate long-term care is an important determinant of future requirements. As has been discussed, care may be regarded as appropriate because 1) it is the least costly way to care for a person, or 2) it is the way that best meets the needs of the person. Obviously, a statement must be made as to which philosophy is likely to underlie future legislation governing public financing of health care.

The factors that govern future requirements for homemaker-home health aides — funding levels, utilization, and philosophy of care—do not lend themselves to projections from historical trends since sharp changes in the projection period are possible, if not likely. Therefore, this paper presents four different sets of assumptions, each set changing the assumption concerning one demand factor, and each yielding a vastly different set of employment requirements projections. One assumption set is selected for special attention because it most closely reflects the current situation and trends; the corresponding projection is the so-called "judgment projection."

Assumption set I continues the status quo into the projection period—it assumes that no changes will occur in the philosophy of appropriate care, legislation regarding home health, or the level of

utilization. These assumptions result in requirements projection set I for homemaker-home health aides—63,000 in 1980, 67,500 in 1985, and 72,000 in 1990. Since the most restrictive set of assumptions forms the basis for requirements projection set I, this is the base line projection providing a minimum for employment requirements during the projection period (see table 3). Although the current trend toward increased utilization makes this alternative unlikely, poor performance of the economy combined with efforts to curtail HEW Federal spending for health and social services could result in employment requirements similar to these.

Assumption set II, while similar to set I, assumes greater utilization of home health services over the next 15 years. Instead of the current situation, in which services authorized by law are not fully utilized, assumption set II assumes full utilization. That is, home health services will be used under Medicare and Medicaid, within the current eligibility requirements, each time this is the least costly way to meet the person's needs. This assumption set also assumes that the various State Title XX plans will include substantial homemaker-home health aide services. Finally, it assumes an awareness by the medical community of the potential of these services, necessary for increased referrals of patients to home health agencies.

Requirements projection set II for homemaker-home health aides resulting from assumption set II is 132,000 in 1980, 178,000 in 1985, and 198,000 in 1990. Current trends support this assumption set. The GAO study cited in Part I recommended that HEW take several actions to increase the utilization of home services under Medicare and Medicaid. Hearings held by the Senate Special Committee on Aging and the House Select Committee on Aging repeatedly endorse greater utilization of home health care. Many current State Title XX plans greatly expand the funds allocated to homemaker-home health aide service. The exposure of nursing home scandals by the news media has created in the general public a new awareness of the potential of home care. Therefore, projection set II is the judgment projection—that projection set based on the assumption set that most closely reflects the current situation and trends.

Assumption set III, like set II, assumes full utilization of home health services. In addition, it assumes a change in legislation concerning home health care of the elderly. These legislative changes expand the coverage for homemaker-home health aide service so that all the elderly (not just the poor) would be eligible for the service on a long-term, chronic care basis. Assumption set III also assumes a strict least-cost criterion for eligibility, as well as strict guidelines to qualify as needing the service (e.g. no family member is available to provide the service). Voluntary agencies currently use such guidelines to determine which cases to accept. These changes could be brought about by expanding services covered by Medicare, for example by extending Medicaid or Title XX coverage to all elderly persons, or by enacting a national health insurance program that includes long-term care.

The projected requirements for homemaker-home health aides under assumption set III are 135,000 in 1980, 218,000 in 1985, and 253,000 in 1990. While current legislation does not support this level of requirements, a legislative change is very possible. The assumptions of change underlying this projection III already are discussed widely as the future direction of long term care

Table 3. Projections of requirements for homemaker-home health aides, under various assumptions, 1980, 1985, and 1990.

Assumptions	Requirements projections 1980	1985	1990	
I. No change	63,000	67,500	72,000	Base line
II. Change utilization only	132,000	178,000	198,000	Judgment projection
III. Change utilization and legislation only	135,000	218,000	253,000	Alternate projection
IV. Change utilization, legislation, and philosophy of appropriate care	140,000	310,000	386,000	Upper limit

[1] See Appendix A for a discussion of projection methods.

for the elderly.[11] Therefore projection set III is the alternate projection, based on assumptions that reflect a reasonable change in the current situation.

The final set of assumptions builds on assumption set III, but changes the criterion for appropriate health care. Instead of assuming that the least costly form of care is appropriate, whatever care best meets the needs of the person is considered appropriate. Many European countries espouse this philosophy, with the attitude that persons should not stay in an institution if their social or medical problems can be solved in other ways.[12] This usually involves extensive homemaker-home health aide services combined with professional social and health services and voluntary support services. Assumption set IV includes both this change in the philosophy of appropriate health care and the changes in legislation required to fund this level of service.

The expected requirements under this assumption set are 140,000 in 1980, 310,000 by 1985, and 386,000 by 1990. Since these projections assume that funding would be available to support a new and potentially expensive type of long-term care, this alternative, while possible, is unlikely. However, just as projection I is a base line below which requirements would not reasonably fall, projection set IV is an upper limit, beyond which requirements would not reasonably rise. It is similar to a projection based on a goals criterion for requirements, the number of aides necessary to serve all elderly persons who could be maintained in the home with this help. The remaining discussion of projected requirements, however, is limited to the judgment and alternate projections, since these are based on assumptions that have a strong possibility of occurrence.

Annual Openings

Openings for homemaker-home health aides result from two factors—growth of the occupation and replacement needs. Under the judgment projection, requirements are expected to grow by 14,000 each year between 1975 and 1980, 9,200 between 1980 and 1985 and 4,000 annually between 1985 and 1990 (see table 4). The alternate projection yields annual openings due to growth in requirements of 15,000 between 1975 and 1980, 16,600 between 1980 and 1985, and 7,000 annually between 1985 and 1990.

The projected annual openings resulting from persons who transfer out of the occupation, however, are far greater than those resulting from growth, even in this very rapidly growing occupation. This high rate of attrition is common to occupations that do not require highly developed skills or specific formal education.[13] Persons who leave an occupation either transfer to another occupation or leave the labor force temporarily or permanently. Conversations with many agency administrators reveal several recurring reasons why aides quite their jobs.

Table 4. Projected annual openings for homemaker-home health aides, 1975–1990

	1975–80	1980–85	1985–90
Judgment projection			
Growth	14,000	9,200	4,000
Replacement	19,200	31,000	37,600
Total	33,200	40,200	41,600
Alternate projection			
Growth	15,000	16,600	7,000
Replacement	19,500	35,300	47,100
Total	34,500	51,900	54,100

Transfers out of the labor force. A large number of homemaker-home health aides who leave the labor force do so temporarily. Many aides are persons who have the responsibility of both supporting and caring for their families. Often family problems such as an ill child or psychological pressures force these aides to quite their jobs temporarily and return to duties in their own homes. On the other hand, many aides do not provide the primary support for the family, but work only long enough to pay a specific debt, to purchase a predetermined item such as a new car, or to help the family get through hard financial times. As soon as they earn the extra income, many of these aides quit their jobs, only to take them again when the financial need arises. This flexible work pattern, encouraged by the availability of part-time work, adds to the temporary transfers of aides out of the labor force.

Since agencies prefer homemaker-home health aides who are mature persons and experienced in

[11] Two pieces of legislation whose provisions would broaden Medicare coverage to include homemaker-home health aide services on a long-term basis (whenever it would prevent institutionalization at a lower cost) were introduced in Congress in 1975—Representative Koch and Senator Moss introduced the National Home Health Care Act, and Senator Beall introduced the Long Term Care Amendments of 1975. Although imminent passage of this or similar legislation is not likely, the proposed bills indicate the seriousness of Congressional interest in helping elderly persons remain in their homes.

[12] *Home Help Services for the Ageing Around the World*, The International Federation on Ageing (Washington, D.C., N.D.).

[13] James J. Byrne "Occupational Mobility of Workers," *Monthly Labor Review*, February 1975, p. 53.

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homemaking and personal care, the number of annual openings that result from deaths and retirements are greater than in occupations that employ large numbers of young workers. However, the chance to work on a part-time or on-call basis encourages many homemaker-home health aides to continue in the occupations long after the normal retirement age.

Transfers to other occupations. A large number of persons who leave the occupation of homemaker-home health aide stay in the labor force, transferring to another occupation. Interviews with service providers indicate that many newly hired home health aides quit their jobs during the first three months of employment because of the nature of the work. Even though agencies screen applicants carefully and attempt to familiarize the new employees with all aspects of the work, many new employees find the housekeeping aspects of the job distasteful, preferring to provide only personal care. Others cannot cope with the hectic pace or pressures of the work, since the assigned work plan usually requires that the homemaker-home health aide perform an extremely full schedule of jobs within 3 or 4 hours.

Transportation presents a major problem for both the homemaker-home health aide and the agencies. The aides generally travel directly to their clients' homes from their own residences. Many aides must rely on public transportation, which often is not adequate and limits the number of clients that a specific aide can serve. Most agencies reimburse the aides for at least part of the cost of travel, a substantial agency expense. However, even with this reimbursement, if the trip requires a long commuting time, the money the aide earns is not sufficient to outweigh the number of hours spent on travel in addition to actual delivery of services. At times, this transportation problem so restricts the number of assignments an aide can accept that the aide must leave the occupation to take a job with a more stable income.

Other aides transfer to another occupation because of low pay or absence of fringe benefits. Wages for homemaker-home health aides vary considerably. Beginning wages ranged from about $2.10 to $3.60 an hour and averaged about $2.60 an hour in 1975, according to limited information available. Agencies in large cities that have a high cost of living generally pay higher wages. Agencies that have union contracts also usually pay higher wages and offer more benefits. While some agencies pay the same rate to all aides, most agencies give pay increases as aides gain experience and are given more responsibility. A few agencies have career ladders, with the increasing responsibilities and wages of each step stated in detail. Limited data indicate that pay for experienced aides averaged about $3.25 an hour in 1975 with some agencies paying over $4.00 an hour.

Benefits vary even more than wages. Some agencies offer no benefits at all, while others offer a full package of holidays, vacation, sick leave, health and life insurance, and retirement plans. While some agencies hire only on-call hourly workers, with no benefits, many agencies employ aides on a full-time or part-time basis with many benefits and a minimum number of hours guaranteed. A typical full-time homemaker-home health aide is guaranteed 36 hours of work a week, earns between $2.75 and $3.25 an hour, depending on length of employment and level of responsibility, has 1 to 3 weeks paid vacation each year, based on number of years of employment, earns 1 day of sick leave a month, is paid for major holidays, and can participate in health insurance and pension plans. A typical part-time employee works a regular schedule and is guaranteed 20 hours of work a week, receives the same hourly wage as full-time employees, and has similar benefits, allocated according to the number of hours worked. A few agencies also allocate vacation and sick leave to those employees who do not have a guaranteed minimum number of hours or a regular schedule.

If higher paying jobs are available, some aides will transfer to them, regardless of their work preference. In an industry-intensive area, for example, homemaker-home health aides may leave their jobs to work in a low-skill occupation in a local factory such as an assembly line worker in the auto industry or a sewing machine operator in the apparel industry. Even if the wage level is similar, better benefits or guaranteed hours of work encourage many transfers to other occupations. This reason for transfers is most frequent in those agencies that only employ aides on an on-call basis, have no benefits, and pay close to the minimum wage.

Homemaker-home health aides often leave their jobs to become nursing aides in hospitals or nursing homes. The work is similar, and the regularly scheduled hours of work provide a more secure income than on-call employment. If an aide needs the guarantee of regular income and local agencies that provide homemaker-home health aide service hire on an on-call basis only, the chances are that the aide will take a job as a nursing aide as soon as the opportunity arises.

Some homemaker-home health aides stop working for the agency in order to work directly for the client. (We will refer to these persons as self-employed "home helps"—the term most often used

in Europe—to distinguish them from other private household workers.) While the duties that self-employed home helps perform may be the same, two elements basic to the occupation of homemaker-home health aide are different: 1) the assessment of need and supervision by the agency are missing, and 2) the ultimate responsibility for the quality of service rests with the worker instead of an agency. Therefore, aides who go to work directly for the client are transferring out of the occupation of homemaker-home health aide, as defined here. Some aides make this change because the client pays more than the agency. However, at the same time, these aides lose any benefits the agency offers, and must locate other clients without the help of an agency at the termination of employment by the original client.

Rate of attrition. Although the National Council's 1973 survey did not collect attrition rates data, a recent informal survey of a small sample of agencies [1] revealed an extremely broad range of attrition rates (4 percent to 50 percent) with a clustering of many rates around 20 percent. Interviews with several service providers further strongly support 20 percent as a representative attrition rate.

While wages and benefits, the flexibility of the work schedule, and transportation arrangements undoubtedly are important factors in the attrition rate for individual agencies, the extremes in the attrition rate also may reflect pressures of the work. Agencies that are cost-conscious as well as concerned with providing quality service may schedule the aides' duties extremely tightly and strictly supervise the aides to assure that all duties are performed. The extreme pressure of the work may result in a very high attrition rate. On the other hand, an agency that employs full-time, salaried homemaker-home health aides but provides little supervision, or allows aides more time than necessary to perform the scheduled tasks, may experience a comparatively low attrition rate, perhaps at the expense of wasted public funds.

The 20 percent representative attrition rate applied to the judgment projection results in annual openings due to replacement needs of 19,200 between 1975 and 1980, 31,000 between 1980 and 1985, and 37,600 between 1985 and 1990. Annual openings due to attrition for the alternate projections are 19,500 between 1975 and 1980, 35,300 between 1980 and 1985, and 47,100 between 1985 and 1990.

[1] Informal survey conducted by Patricia A. Gilroy, Executive Director of the Homemaker Health Aide Service of the National Capital Area, Inc.; data unpublished.

Total annual openings. Adding these openings due to attrition to the openings resulting from growth in the occupation yields total projected annual openings for the period. Under the judgment projection, openings would number 33,200 annually between 1975 and 1980, 40,200 between 1980 and 1985, and 41,600 between 1985 and 1990. The alternate projection yields 34,500 annual openings between 1975 and 1980, 51,900 between 1980 and 1985, and 54,100 between 1985 and 1990.

While there is a substantial difference between the annual openings of the judgment and the alternate projections in later years, the manpower implications for the two projections are similar. Even the judgment projection calls for more than one and one-half times as many new homemaker-home health aides each year as were employed in 1975. With annual openings of this magnitude, the supply issues, occupational outlook and potential employment problems are substantially the same for both the judgment and the alternate projections, although problems would likely occur soon under the alternate projection.

D. Supply Issues

The supply for occupations that require no specific formal education, such as homemaker-home health aides, consists of 1) all persons employed in the occupation, plus 2) unemployed persons and currently employed persons searching for another occupation who meet the requirements for experience and personal qualifications. Although the number of persons in this supply cannot be estimated or projected, the following insights into why and how persons enter the occupation of homemaker-home health aide (gleaned from interviews with service providers) give some picture of supply issues.

Supply Source

The supply of persons available to fill the annual openings for homemaker-home health aides consists of all mature, healthy persons actively searching for employment (full-time, part-time, or on call) who can read and write and who have experience (not necessarily paid employment) in homemaking and personal care. Homemakers who have raised their own families and are either entering the labor force for the first time or reentering after several years form the major supply source. Another important source is persons who transfer from other occupations, especially nursing aides and domestics. Post-secondary students in a related course of study such as nursing or home economics are a minor supply source for part-time or summer employees.

In addition to the requirements of literacy and of homemaking and personal care experience, persons must have a desire to help others before they are part of the supply of homemaker-home health aides. Agencies attempt to screen applicants who do not have this personal quality. Since the job requires an awesome amount of responsibility and hard work compared with the wages earned, persons without a deep desire to help others either would not choose the occupation or would soon leave it. The element of personal satisfaction that this occupation provides is, at the same time, a factor in attracting workers to the job.

Some persons are attracted because it is so much like caring for one's own family. Many mature persons who do not have any specific job skills and who are entering the job market for the first time feel qualified for this occupation. The availability of part-time work and the opportunity to determine one's own work schedule make this occupation attractive to many persons. Service providers report that nursing aides often transfer into the occupation of homemaker-home health aide because they want the shorter, more flexible hours or because they dislike shift work. The relative independence enjoyed by homemaker-home health aides in performing their assigned work and the increased opportunities for initiative also attract some nursing aides.

The importance and visibility of the occupation also attract workers. Compared with other occupations that require no specific training, homemaker-home health aides enjoy a sense of status. They are part of a health care team, and make a major contribution to ongoing case assessment. In most agencies, aides wear uniforms and an official patch that set them apart and contribute to a sense of pride in their occupation.

The effect of wages and benefits on the actual supply of homemaker-home health aides is variable. Agencies that pay very low wages and offer no benefits attract sufficient workers, although some aides may transfer when better paying jobs are available. Other agencies pay comparatively high wages and offer a full range of benefits. Although these agencies may attract many applicants, earnings alone do not keep new employees in the occupation. Without the fundamental desire to help others, the hard work, demanding schedule, and sometimes unpleasant clients or tasks soon drive new employees out of the occupation, even in those agencies that pay the higher wages.

Recruitment and Training

Identifying the reasons persons become homemaker-home health aides is one important supply issue. Learning how they find out about job openings is another. Most recruitment of homemaker-home health aides is accomplished by word of mouth. Agencies inform current employees of openings for aides, and they pass the word among their friends. Many agencies have long waiting lists of persons who have heard of the service through current employees or clients and who wish to apply as an aide. Occasionally agencies advertise openings in a local newspaper or community bulletin, especially if they need an aide who speaks a foreign language. T.V. spots that inform the public both of the availability of the service and of the need for aides have drawn an overwhelming number of applicants to new voluntary agencies. Generally, however, no formal recruitment is necessary to fill openings in this occupation—an indication of the vast potential supply of homemaker-home health aides.

Shortly after they are hired, homemaker-home health aides undergo orientation and training. The length and quality of this training vary greatly, with agencies that require experience as a nursing aide generally providing a minimum of orientation. Most agencies, however, provide a one or two week training program. Topics covered include basic nutrition, meal planning and preparation, personal care of the sick, such as bathing, turning and lifting bed patients, emotional problems accompanying illness, and the aging process and behavior of the elderly.

Supervisors given additional training informally, as required for specific case assignments. As aides take on a variety of cases, they develop expertise in caring for persons with many types of illness. Some aides discover a special talent for caring for a specific type of client, such as persons who need help with prescribed exercises, or clients with failing eyesight. In some larger agencies experienced homemaker-home health aides can specialize in caring for clients with a specific type of problem.

In addition to on-the-job training given by supervisors, many agencies offer seminars from time to time on specific topics such as diets for diabetics, exercises for clients with a heart condition, or ways of coping with depression. As aides gain experience in different types of cases, they can assume more responsibility and become more self-directing, within the scope of their assigned duties. In some agencies, an experienced aide can be promoted to a special assistant to the supervisor, relieving the supervisor of some of the more routine aspects of supervision and case management.

E. Employment Outlook

This section presents the employment outlook for homemaker-home health aides, discussing the ability of supply to meet the projected requirements for aides. Actions to assure that supply will be sufficient to meet requirements through the 1980's are suggested, and comments are offered on the related topic of the quality of care.

Supply-Demand Analysis

A strict supply-demand comparison is impossible for homemaker-home health aides since the supply cannot be quantified. However, broad generalizations concerning the availability of persons to fill the openings during the projection period can be made.

The current abundance of applicants to fill unadvertised homemaker-home health aide positions indicates that the supply of the aides would be sufficient for a vast increase in requirements. As has been noted, the expected requirements and attrition under both the judgment and the alternate projections result in very large numbers of annual openings each year. Nevertheless, the vast supply of aides should be sufficient to fill openings for several years. As the supply of new aides decreases, however, many agencies that currently require experience as a nursing aide may have to drop this requirement. Instead, these agencies would have to supply the training and additional supervision required for persons who are inexperienced, increasing these agencies' costs.

In the later years of the projection period (or sooner, under the alternate projection), the supply of homemaker-home health aides probably will need to be increased to meet requirements by 1) actions that would attract more applicants, or 2) actions that would help retain employees. Agencies could increase applicants by actively recruiting employees, using newspaper listings, employment services, and perhaps radio or T.V. spots. Those agencies that pay lower wages or no benefits could offer a more attractive earnings package. Agencies that offer only on-call employment could add salaried positions, and those that employ only full-time homemaker-home health aids could add jobs with short and flexible hours in order to attract persons with a variety of needs in employment status. This flexibility in scheduling also would enable aids to continue employment in the agency even though their employment status needs change between full and part-time work.

Other means to increase supply by reducing turnover center on job satisfaction. While some agencies actively promote feelings of status and accomplishment among aides, many do not. Frequent conferences between aides and supervisors are essential for employee morale. These meetings give the aide a chance to relate apparent changes in the physical and mental health of the patients, fulfilling the aides' role in case assessment. The meetings also provide a chance for the supervisor to comment on the development of the aide, reinforcing positive performance and discussing any unacceptable aspects, giving the aide a chance to improve. Such active attempts to make aides feel that their work is important and that they are performing it well will become increasingly necessary as positions become harder to fill.

A chance for advancement in the occupation also improves job satisfaction. Many agencies increase responsibilities and pay as a reward for good work and for time in employment. Agencies that do not have some type of advancement opportunities could introduce a career ladder to help attract a sufficient number of aides as positions become difficult to fill in the latter part of the projection period.

Quality of Care Discussion

Many persons in the home health field are concerned about a deterioration in the quality of care as demand for home care grows. A previous section discussed the difference between Medicare and Medicaid, which provide guidelines for quality assurance, and Title XX of the Social Security Act, which places the responsibility for setting quality guidelines with the States. Many critics envision abuses of elderly clients similar to those that have come to light during the nursing home investigations. Critics also fear misuse of Title XX monies. These persons foresee the emergence of agencies that are little more than employment agencies for domestics, with virtually no supervision of the aides, no plan of duties to be performed, and no professional assessment of the initial or on-going need for the services—and they envision these agencies becoming profit-rich from welfare service funds. Other persons concerned about delivery of home health services fear overregulation that would needlessly increase agency costs. Supervision and training are two key elements in this complex quality of care issue.

Supervision. Assuming that supervisors monitor the quality of care, an ideal ratio of aides per supervisor would be a useful guideline. However, this ratio would vary greatly according to the experience and employment status of the aides, the number of different clients each serves, and the nature of the clients' illnesses. Some service providers argue that any ideal number of aides per supervisor would be arbitrary, increasing costs beyond necessity for the many clients who can

supervise the work of the aides themselves. While these clients are physically limited in their ability to perform routine personal care or homemaking tasks, they are mentally and emotionally in good health. In these cases, the client could report unacceptable performance of the aides to the agency, eliminating the need for routine visits by a supervisor, according to these service providers. In other cases, if a working spouse or other responsible person lives with the client, they could provide sufficient supervision by observing the tasks that the aide has performed during the day.

These extreme positions on supervisions needs becomes central issues in discussions of the cost of the service. Since supervisors are professional social workers or nurses, they add substantially to the cost per visit. However, a good supervisor constantly assesses changes in the needs of the client and adjusts the service plan accordingly. Since these clients only receive necessary services, they often regain independence much more quickly than clients who become dependent on unnecessary services. This often results in a lower cost per case, even though the cost per visit is relatively high.

While lawmakers must protect the elderly who could be abused if sufficient supervision were not offered, they also must see that public funds are not wasted because of rigid regulations, weighing the costs and economies of supervision. The proper middle ground is not clear, but the need to find it is.

Training. In addition to supervision, the training provided for the aides affects the quality of care. While Medicare has general guidelines, Medicaid and Title XX leave the responsibility of determining required training—if any—to individual States. Since training is provided by agencies before aides start working, it presents difficulties for the typical agency with a cash flow problem. The high turnover rate, especially during the first few months of employment, greatly increases the cost of training. As annual openings become harder to fill and fewer experienced aides are available, the cost of training will rise further. As an alternative, community or junior colleges could offer the training. This would support quality care and, at the same time, reduce the cost of providing the service. This arrangement would require the educational system to work closely with local agencies to determine the number of openings to be filled. The training could include both the initial two or three week course, plus regular follow-up lectures or workshops on pertinent topics. Whether the training is given by the agency or by a local educational institution, assurance of quality care requires that all agencies providing homemaker-home health service follow standard guidelines for this training program.

Chore Service. A discussion of the quality of care should comment on chore service, funded in many States under Title XX. Chore workers perform many of the same homemaking tasks as homemaker-home health aides. There is no uniform definition of the tasks performed by chore workers or of the level of supervision they receive, since each State defines the services funded by Title XX. However, in some States, chore service involves no training and little supervision other than that provided by the client. These chore workers can provide a necessary service to self-directing elderly persons who need help with homemaking tasks. However, whether the source of payment is public funds or the client, the opportunities for abuse abound when the client is incapable of supervising the employee's work.

F. Related Employment Implications

The projections of requirements for homemaker-home health aides contain implications for the requirements for supervisors. At the same time, the development of new models for delivery of home health service and the future for chore workers and self-employed home helps affect the projected requirements for aides. This section discusses these employment implications.

Implications for professional nurses and social workers. Since employment data are not available for supervisors, the average ratio of supervisors to homemaker-home health aides is not known. Therefore, requirements projections for supervisors cannot be made. The uncertainties concerning quality guidelines further cloud the future requirements for supervisors. However, the substantial growth in requirements for homemaker-home health aides under the judgment and the alternate projections indicate that many new positions for supervisors will open each year throughout the projection period. During this time, the supply of registered nurses and social workers entering the labor force is expected to grow faster than traditional employment opportunities for these professional occupations. Therefore, the openings for supervisors should be easily filled through the projection period, providing expanded employment opportunities for registered nurses and social workers.

Implications of the use of chore workers and self-employed home helps. A previous section pointed to the concern for quality of care expressed by leaders in the home health field, and the apprehen-

curve I. This requirements projection, based on the most restrictive set of assumptions, a continuance of the status quo, is the base line projection.

The requirements projection curve under assumption set II, full utilization of services available under present legislation, follows the historical trend projection through the 1970's, then curves out to closely approach the assumption constraint curve II by 1990. The requirements projections for homemaker-home health aides under this assumption set are 132,000 in 1980, 178,000 in 1985, and 198,000 in 1990. This is the judgment projection, based on assumptions that most closely reflect the current situation and realistic trends.

The requirement projection curve under assumption set III, full utilization under a broadened legislation, follows the historical trend projection curve through 1981, and then curves out to closely approach assumption constraint curve III by 1990. The projected requirements for homemaker-home health aides under these assumptions are 135,000 in 1980, 218,000 in 1985, and 253,000 in 1990. This is the alternate projection, resulting from assumptions that very possibly could occur but that would require changes in current legislation.

Assumption set IV yields a project curve that follows the historical trend projection curve through 1984, then curves out to closely approach assumption constraint curve IV by 1990. The expected requirements under this assumption set are 140,000 in 1980, 310,000 by 1985, and 386,000 by 1990. Since these projections assume that funding will be available to support a new and potentially expensive type of long-term care, this alternative is highly unlikely. However, just as Projection I forms a base line, Projection IV forms an upper limit for employment requirements.

the expected hiring difficulties during the latter part of the projection period.

A third type of model project mobilizes volunteers to provide homemaker-home health aide services. Church or civic groups occasionally organize this volunteer service, generally limiting the service to other group members or to a local community. However, this is not a significant source of homemaker-home health aides. The in-home services provided by volunteers most often are those described in Part I as support services —friendly visiting, telephone reassurance, meals on wheels, and so forth. Nevertheless, to the extent that volunteers provide homemaker-home health aides services, the employment requirements for homemaker-home health aides decrease.

APPENDIX A

Methods for Projections of Employment Requirements for Homemaker-Home Health Aides

Many studies have attempted to estimate the current need for home care, but their numerical results differ widely. The report, *New Perspectives in Health Care for Older Americans*, by the House Select Committee on Aging, Subcommittee on Health and Long-Term Care, summarizes just a few of these studies.[19] However, since the purpose of this paper is to project the number of jobs that will be available for aides, the appropriate question is how many persons will demand the service, rather than how many persons need the service. This economic demand for the service can then be translated into employment requirements for homemaker-home health aides.[20]

The text of this paper contains four projections series for requirements for homemaker-home health aides, based on assumptions that reflect different trends in the demand factors for their service—utilization, legislation, and philosophy of need for homemaker-home health aide services. For the sake of completeness, the discussion of the assumption sets is repeated here in the context of projection methods.

Assumption constraint curves for employment. Each set of assumptions establishes an upper limit for employment. For example, under the current Social Security legislation, funding ceilings, State matching requirements, and restrictions on eligibility and on services provided limit the purchase of services. This limitation on demand causes a limitation on the requirements for homemaker-home health aides during each year of the projection period, forming assumption constraint curves for employment.

Assumption set I continues the status quo into the projection period—no changes in the philosophy of appropriate care, legislation regarding home health, or the level of utilization. To project employment under these assumptions, the ratio of aides to the total population in 1975 is held constant as the population increases throughout the projection period.[21] The resulting maximum employment each year is shown in assumption constraint curve I, ranging from 60,000 aides in 1975 to 72,000 in 1990 (see chart A-1).

Assumption set II is similar to I, except that the current underutilization of services is changed to full utilization under the current legislation. This assumes that home health services will be used under Medicare and Medicaid, within the current eligibility requirements, each time this is the least costly way to meet the person's needs. It also assumes that the various State Medicaid and Title XX plans will include substantial homemaker and home health services. Finally, it assumes an awareness on the part of the medical community of the potential of these services, resulting in increased referrals of patients to home health agencies.

Under assumption set II, all currently eligible persons would receive care. Data from homemaker-home health aide service agencies indicate that, on the average, for every client who is accepted, one who also is eligible for the service is turned away. The aides required to provide the service for these registered eligibles would be double the 60,000 employed in 1975. In addition, persons in institutions who could be cared for at home would require the services of a homemaker-home health aide under these assumptions. Widely varying estimates are given for the percent of the institutionalized elderly involved. According to a January 1975 study conducted for HEW, "between 14 and 25 percent of the approximately 1,000,000 elderly in skilled and intermediate care nursing homes could receive appropriate care in their homes."[22] Using 20 percent of 1,000,000 and applying the current ratio of approximately 4.55 cases per aide, the maximum number of aides that could be employed in 1975 under these assumptions is 164,000. Keeping the ratio of aides to the total population constant, assumption constraint curve II reaches 198,000 by 1990.

Assumption set III includes the full utilization of assumption set II, but adds changes in legisla-

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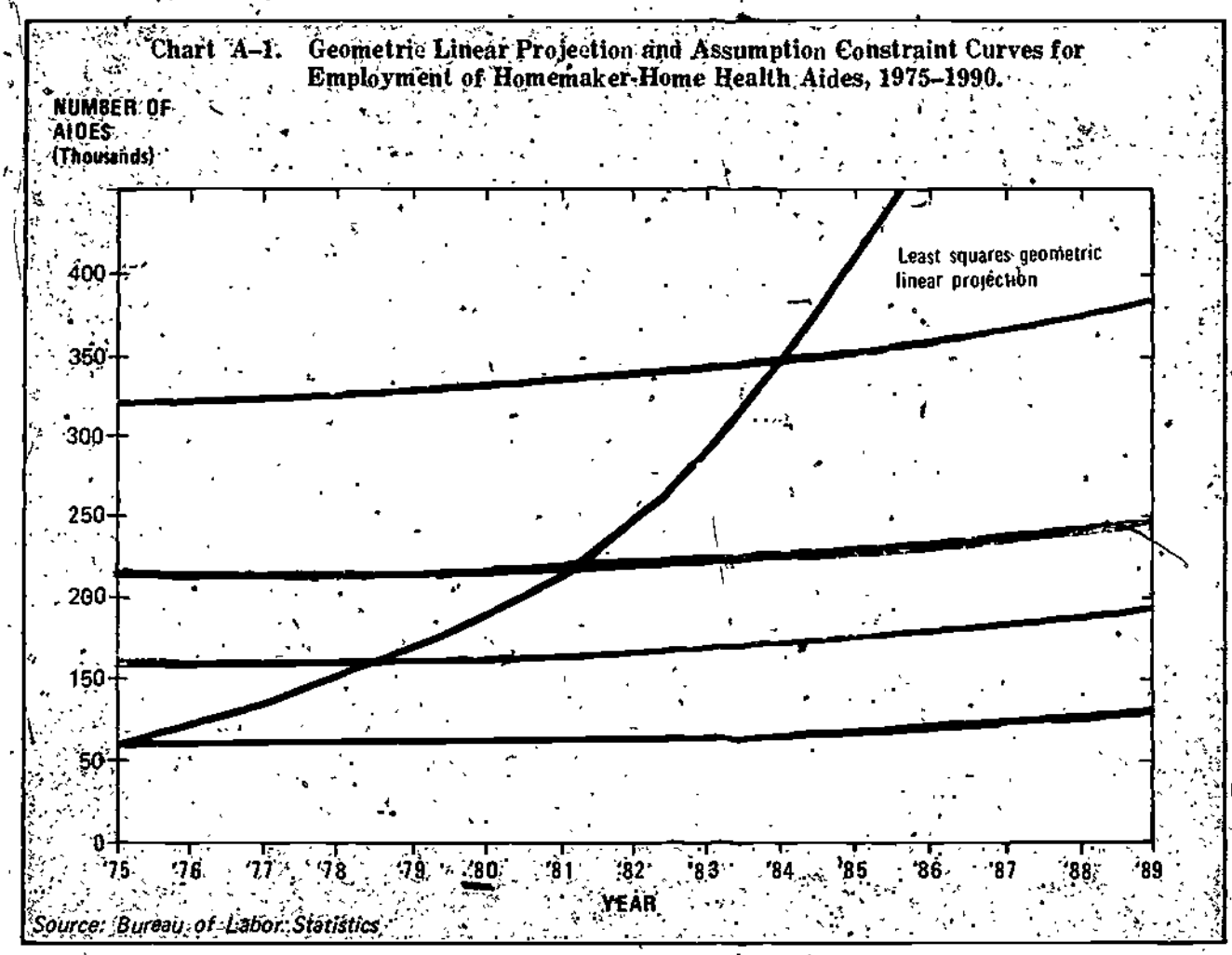
[19] *New Perspectives in Health Care for Older Americans* (U.S. House of Representatives, Select Committee on Aging, 94th Cong., 2nd sess., 1976, Committee Print), pp. 22-25.

[20] Since this occupation is not a separate census classification and is not broken out in the Current Population Survey, the usual BLS methods for projecting occupational requirements (occupational/industry matrix approach) could not be used. Given the wide range of estimates of need, lack of expenditure data, and the curvilinear historical employment trend, sophisticated projection methods cannot be used. Since the methods used here contain the unpredictable element of personal response to an available service, in addition to estimates from other studies of need for the service, these projections should be viewed as gross estimates rather than precise figures.

[21] For population projections, see *Current Population Reports, Population Estimates and Projections*, series P-25, No. 601 (Bureau of Census, October, 1975) Table F, Series I, P. 8.

[22] Cited in *New Perspectives in Health Care for Older Americans*, p. 23.

Chart A–1. Geometric Linear Projection and Assumption Constraint Curves for Employment of Homemaker-Home Health Aides, 1975–1990.



Source: Bureau of Labor Statistics

tion concerning home health care of the elderly. These changes would expand the coverage for homemaker-home health aide service so that all the elderly (not just the poor) would be eligible for the service on a long-term, chronic care basis. It assumes a strict least-cost criterion for eligibility, as well as strict guidelines for qualifying as truly needing the service (e.g. no family member is available to provide the service). Voluntary agencies currently use such guidelines to determine which cases to accept. These changes could be brought about through an expansion of Medicare or through a national health insurance program.

Analysis of several studies indicates that approximately 950,000 persons needed formal in-home services in 1975, using strict eligibility requirements. This demand for the service indicates maximum employment requirements under these assumptions of 209,000 in 1975. Assumption constraint curve III increases with the population to 253,000 in 1990.

The final set of assumptions builds on assumption set III, but replaces the least-cost criterion for appropriate health care with the criterion that whatever care best meets the needs of the person is appropriate. Many European countries espouse this philosophy, holding the general attitude that nobody should stay in an institution if his social or medical problems can be solved in other ways.[3] This usually involves extensive professional social and health services and voluntary support services. Assumption set IV includes both this change in the philosophy of appropriate health care and the changes in legislation required to fund this level of service. The assumption constraint curve IV, which traces the maximum employment requirements for homemaker-home health aides under these broad assumptions, ranges from 320,000 in 1975 to 384,0080 in 1990. These projections are based on the experience in England which in-

[3] *Home Help Services for the Aging Around the World*, The International Federation on Aging (Washington, D.C., N.D.)

dicates that 150 aides are needed for every 100,000 persons.[23]

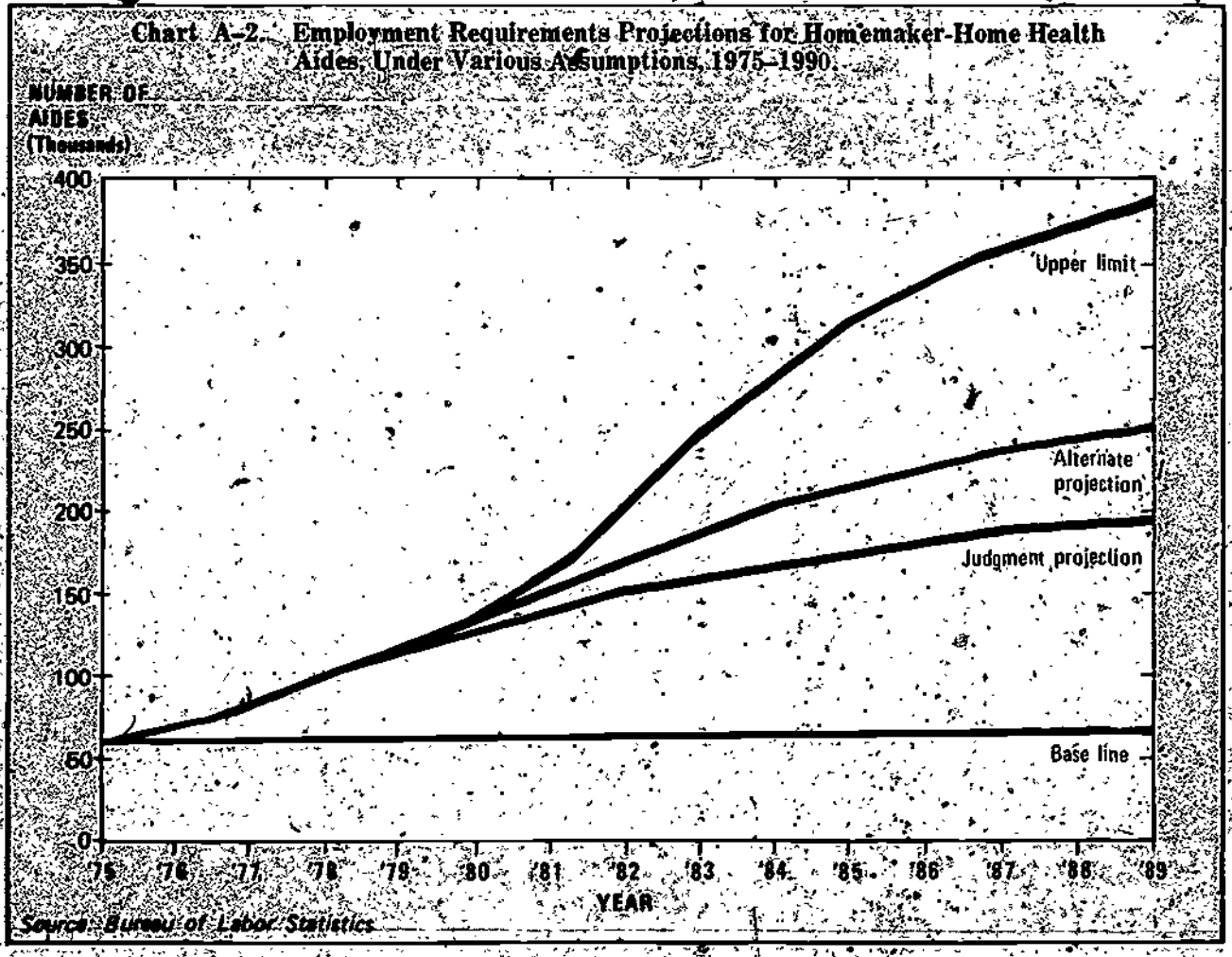
Projection from historical trends. The historical employment of homemaker-home health aides has been discussed. The trend line that presents data in survey years from '58 to '73 (text chart 8) is clearly curvilinear, with employment growing faster in the later years. The geometric least squares projection of this historical trend results in an estimated 60,000 aides in 1975, and requirements of 140,000 in 1980 and 360,000 in 1985 (chart A-1 shows the 4 assumption constraint curves and the least squares projection curve). Since the nature of a curvilinear trend results in astronomical long-term projections, these projections after 1985 can be discounted. Furthermore employment requirements cannot be greater than those represented by assumption constraint line IV under any of the assumption sets. Since the projection curve intersects assumption constraint curve IV in 1985, the least squares projection curve is useless after 1985.

Employment requirements projections. Combining the projected historical trend curve with various assumption constraint curves yields the requirements projections under each of the 4 assumption sets. In each case, the trend projection curve is followed until it intersects the appropriate assumption constraint curve, then the constraint curve is followed through the remainder of the projection period. Since sharp changes in the level of employment generally do not occur from one year to the next, these basic curves are smoothed out to produce the requirements curves under each assumption set (chart A-2).

Since, with the exception of the first year in the projection period, assumption constraint curve I is below the trend projection line, the projection line for assumption set I is the same as constraint

[23] Ibid., pp. 16, 22. This official goal in Great Britain is conservative compared with other estimates of need for between 300 and 400 aides per 100,000 population. However, the lower figure is used here as a "ball park" estimate of a reasonable level of demand under this assumption set.

Chart A-2. Employment Requirements Projections for Homemaker-Home Health Aides, Under Various Assumptions, 1975–1990



Source: Bureau of Labor Statistics

curve I. This requirements projection, based on the most restrictive set of assumptions, a continuance of the status quo, is the base line projection.

The requirements projection curve under assumption set II, full utilization of services available under present legislation, follows the historical trend projection through the 1970's, then curves out to closely approach the assumption constraint curve II by 1990. The requirements projections for homemaker-home health aides under this assumption set are 132,000 in 1980, 178,000 in 1985, and 198,000 in 1990. This is the judgment projection, based on assumptions that most closely reflect the current situation and realistic trends.

The requirement projection curve under assumption set III, full utilization under a broadened legislation, follows the historical trend projection curve through 1981, and then curves out to closely approach assumption constraint curve III by 1990. The projected requirements for homemaker-home health aides under these assumptions are 135,000 in 1980, 218,000 in 1985, and 253,000 in 1990. This is the alternate projection, resulting from assumptions that very possibly could occur but that would require changes in current legislation.

Assumption set IV yields a project curve that follows the historical trend projection curve through 1984, then curves out to closely approach assumption constraint curve IV by 1990. The expected requirements under this assumption set are 140,000 in 1980, 310,000 by 1985, and 386,000 by 1990. Since these projections assume that funding will be available to support a new and potentially expensive type of long-term care, this alternative is highly unlikely. However, just as Projection I forms a base line, Projection IV forms an upper limit for employment requirements.